

U.S. COMMISSION ON CIVIL RIGHTS

Health Care Disparities



BRIEFING
REPORT



DECEMBER 2010

U.S. Commission on Civil Rights

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- Investigate complaints alleging that citizens are being deprived of their right to vote by reason of their race, color, religion, sex, age, disability, or national origin, or by reason of fraudulent practices.
- Study and collect information relating to discrimination or a denial of equal protection of the laws under the Constitution because of race, color, religion, sex, age, disability, or national origin, or in the administration of justice.
- Appraise federal laws and policies with respect to discrimination or denial of equal protection of the laws because of race, color, religion, sex, age, disability, or national origin, or in the administration of justice.
- Serve as a national clearinghouse for information in respect to discrimination or denial of equal protection of the laws because of race, color, religion, sex, age, disability, or national origin.
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Health Care Disparities

A Briefing Before
The United States Commission on Civil Rights
Held in Washington, DC

Briefing Report

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Executive Summary

The federal government defines health care disparities as the persistent gaps between the health status of minorities and non-minorities in the United States. According to the National Partnership for Action to End Health Disparities (a division of the Department of Health and Human Services), despite continued advances in health care and technology, racial and ethnic minorities continue to have more disease, disability, and premature death than non-minorities.

In a briefing held on June 12, 2009, the Commissioners chose to examine health disparities through the microcosm of cardiovascular disease and the related condition of hypertension. Conditions arising from cardiovascular disease are the leading cause of death in America, cutting across all racial and ethnic groups, socioeconomic levels, and affecting both men and women. Within this context, the Commissioners heard experts discuss relevant data and their conclusions as to why disparities persist, possibly flawed conclusions resulting from omission of important variables in earlier studies such as the 2002 Institute of Medicine report, health care delivery system differences, recent and ongoing research, access to care and quality of care, patient behavior, and other aspects of differences between population groups in terms of cardiac/hypertension health and cardiac/hypertension care.

Panelists did not agree on the causes of disparities in both health status and health care. Factors included receiving care from health care providers who were not Board-certified; bias resulting from insufficient numbers of minorities in the health care workforce; inadequate health insurance coverage and the high cost of healthcare; lack of data available for specific populations; differences in provider expertise and use of diagnostic and treatment resources; and geographic and demographic distributions.

The American Heart Association testified that its prepared guidelines help doctors improve diagnosis and treatment for coronary artery disease, heart failure and stroke. The Jackson Heart Study, a single-site longitudinal study of African-American cardiovascular health, examines psychosocial, nutritional, metabolic, and genetic effects on cardiovascular disease. The Strong Heart Study, a population-based survey and the first to highlight the higher rates of cardiovascular disease among American Indians and other populations with high rates of diabetes, focuses on American Indian communities and has trained non-physician providers to offer certain medical services. *Expecting Success*, the first collaborative undertaking by a group of hospitals to eliminate disparities, concentrates on improving cardiac care for African-Americans and Latinos.

At the completion of their testimony, the panelists fielded questions from the Commissioners on such issues as how problems with data collection in the 1990 and 2000 census skewed results for Native Americans; the percentage of the health care disparities caused by factors outside the health care delivery system; the portion of health care disparities related to possible bias; the extent to which linguistic and cultural competency affect access to and the quality of treatment in health care; research that attempts to explain disparities existing between rural, suburban and urban areas; the lack of public awareness as to the differences in

quality among various medical facilities with respect to high-quality health care; the quality of health care received in inner-city hospitals; success in developing procedures and training for non-physicians who can work in underserved communities; and why the gap in disparities continues for some minorities but has closed for others.

Panelists were the Honorable Louis W. Sullivan, Chairman, Sullivan Alliance to Transform America's Health Professions; Dr. Garth Graham, Deputy Assistant Secretary for Minority Health, U.S. Department of Health and Human Services; Dr. Rubens Pamies, Professor of Medicine, University of Nebraska Medical Center; Dr. Amitabh Chandra, Professor of Public Policy, John F. Kennedy School of Government at Harvard University; Dr. Sally L. Satel, Resident Scholar at the American Enterprise Institute; Dr. Peter Bach, Assistant Attending Physician, Department of Epidemiology and Biostatistics at Memorial Sloan-Kettering Cancer Center; Dr. William Lewis, Cardiologist, American Heart Association; Dr. Herman Taylor, Professor of Medicine, Jackson Heart Study, Jackson Medical Mall; Dr. Barbara V. Howard, Senior Scientist, Medstar Research Institute; and Dr. Bruce Siegel, Director, Center for Health Care Quality, George Washington University School of Public Health and Health Services.

A transcript of this briefing is available on the Commission's Web site, www.usccr.gov, and by request from the Publications Office, U.S. Commission on Civil Rights, 624 Ninth Street, NW, Suite 600, Washington, DC, 20425, (202) 376-8128, TTY (202) 376-8116, or via e-mail at publications@usccr.gov.

Panelist Statements: First Panel

Note: Statements are unedited by the Commission and are the sole work of the author.

Louis W. Sullivan

Background

The Sullivan Alliance to Transform America's Health Professions is a national effort to enhance health workforce diversity initiatives around the country. The Sullivan Alliance was organized in January of 2005 to act on the reports and recommendations of the Sullivan Commission (Missing Persons: Minorities in the Health Professions, September, 2004), and the Institute of Medicine Committee on Institutional and Policy-Level Strategies for Increasing the Diversity of the U.S. Healthcare Workforce (In the Nation's Compelling Interest Ensuring Diversity in the Healthcare Workforce, February, 2004). In its report, the Sullivan Commission described the current situation: ". . . Too many Americans are suffering life or death consequences . . . The time is right and our citizens are anxious for action." The report further concluded "the fact that the nation's health professions have not kept pace with changing demographics may be an even greater cause of disparities in health access and outcomes than the persistent lack of health insurance for tens of thousands of Americans."

The Nation's Health Workforce

The strength of our health workforce is central to the capacity of our healthcare system.

The PriceWaterhouseCoopers Health Research Institute predicts a shortage of 24,000 physicians by 2020 (5) supporting a call by the Association of American Medical Colleges for a 30 percent increase in medical school enrollment and an expansion of graduate medical education positions by the year 2015 (4, 6). A severe nursing shortage has been reported by the vast majority of U.S. hospitals, and the U.S. Department of Health and Human Services projects that by 2020 the shortage of nurses will be between 400,000 and 1 million (5). The Association of Schools of Public Health estimates that by the year 2020, 250,000 more public health workers will be needed in the nation (7). Lastly, a shortfall of more than 150,000 pharmacists is projected by 2020 (8, 9).

The current shortage of health professionals is exacerbated by a maldistribution of physicians by geography and specialty. It is well documented that there is a critical shortage of primary care and family physicians (5, 10-12). In addition there is a dearth of health providers in rural and inner city areas which have been designated by the U.S. Public Health Service as health professions shortage areas (HPSA). As of 2005 there were more than 5,500 HPSA throughout the United States (13). In 2008, more than 35 million Americans lived in areas that were designated as underserved – lacking primary care physicians, dentists and mental health professionals (14).

The 2007 data from the U.S. Census Bureau indicate that one third of the U.S. population (34 percent) is a racial or ethnic minority (15). More than 50 million Americans speak a language other than English at home (16). Furthermore, U.S. census projections show that racial and ethnic minorities will become the majority of the U.S. population by 2042 (3). Today,

African-Americans, Hispanic Americans, and American Indians make up (sic) of the U.S. population. In 2004, according to the Sullivan Commission report “Missing Persons: Minorities in the Health Professions,” minorities made up only 9.4 percent of nurses, 6.1 percent of physicians, (sic) of dentists and 6.9 percent of psychologists (17).

There are a host of barriers impeding access to a health professions career by ethnic and racial minorities. These include poor awareness of health professions careers and their academic requirements, financial barriers, academic preparation, and lack of role models and mentors (22-28).

The Case for Health Workforce Diversity

At this time, when the U.S. supply of health professionals is not keeping pace with growing needs, the U.S. population is increasingly diverse racially and ethnically. Today, minorities account for 43 percent of Americans under 20 (2) and it is projected that over the next two decades minority student enrollment in our nation’s colleges will reach nearly 40 percent (29). Considering these population trends, Cohen and Steinecke (30) state that “increasing physician supply and increasing diversity [in the health professions] are both critically important and are inseparable goals.”

The dearth of minorities in the nation’s health workforce is a major factor contributing to health disparities. Achieving greater racial and ethnic diversity of the nation’s health professionals has distinct benefits (21). First, minority physicians are more likely to practice in medically underserved areas and care for patients regardless of their ability to pay (21, 31-34). Secondly, minority physicians are more likely to choose primary care practices (11) and minority registered nurses are more likely to be employed in nursing and work full time (20), thus improving the care of vulnerable populations. Finally, a diverse health workforce encourages a greater number of minorities to enroll in clinical trials designed to alleviate health disparities (35).

There is evidence that the intellectual, cultural sensitivity and professional competency of all students is enhanced by learning in an ethnically and racially diverse educational environment (31, 36-38). And, also there is evidence that a workforce equipped to serve culturally and linguistically diverse individuals increases the number of initial visits, results in higher utilization of care, enhances high quality encounters, lowers medical errors and reduces emergency room admissions (39-41).

There is also an ethical issue with the U.S. importing foreign medical graduates and nurses from poor third world countries to address the needs of the U.S. healthcare system. These foreign-trained health workers provide a “band aid” approach to a lingering crisis, while depleting third world countries of valuable human resources needed for their own populations.

Discussions

The reforms needed to improve the nation’s health system, the health status of our citizens and to provide leadership in global health are a significant challenge.

Healthcare reform is a prominent focus for the Obama administration and the new Congress. They have the challenge and the opportunity to develop a successful model for health reform. By addressing the central issue – the health care workforce – the administration and the Congress can lead the effort for needed changes in our healthcare system.

Such an effort must not only address the lack of health insurance and/or underinsurance of more than 47 million U.S. citizens and the high costs of health care, it must also focus on the current – and increasing – shortage and maldistribution of health professionals and the need for more racial and ethnic diversity among the nation's health professionals.

All of these factors have a significant impact on access to health care, protecting and improving the health of Americans, and eliminating disparities in health status of the nation's racial and ethnic minorities. The Sullivan alliance and the nation's health professions associations are committed to working with the Obama administration and with the Congress in efforts to reform the nation's health system.

I thank you for this opportunity to present these issues to the U.S. Commission on Civil Rights. I look forward to your questions, and your comments and your support in these efforts to achieve our goal of eliminating disparities in health status and in access to health care.

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Garth N. Graham

It is a pleasure to present to the Commission on Civil Rights on the causes of Health Care Disparities, populations most affected by these disparities, and actions needed to eliminate them.

The mission of the Office of Minority Health (OMH) is to improve the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate health disparities. OMH is located in the Office of the Secretary, Office of Public Health and Science. OMH advises the Secretary, Deputy Secretary, and the Assistant Secretary of Health on public health policies and programs that impact racial/ethnic minorities, and coordinates HHS-wide efforts that address minority health issues.

Health disparities can be defined as significant gaps or differences in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in the population as compared to the health status of the general population. The Institute of Medicine defines disparities in health care as racial or ethnic differences in the quality of health care that are not caused by differences in clinical need, patient preferences, or appropriateness of intervention (Unequal Treatment, Institute of Medicine, 2002).

Overall health status in the U.S. has improved significantly as demonstrated by the dramatic increase in life expectancy for whites (from 47.6 to 77 years) and blacks (from 33 to 72.2 years). However, in spite of the many improvements in health over several decades, significant gaps still exist by race, ethnicity, gender, disabilities, and other related sub populations with respect to premature death and preventable disease. These gaps may in part be related to demographic changes in the U.S. population. According to the 2000 census data (U.S. Census Bureau, 2000), the population of the U.S. grew by 13 percent over the last decade, and has increased in diversity at even a greater rate. Racial and ethnic minorities are among the fastest growing of all communities in the country, and today comprise approximately 34 percent of the total U.S. population. It is projected that by 2030, 40 percent of the population will be non-white (U.S. Census Bureau, 2004). Consequently the U.S. is not only experiencing greater diversity, but people are living longer, experiencing rising costs of health care, and emerging new diseases pose additional challenges to efforts to eliminate health disparities.

While racial and ethnic diversity is increasing, minorities tend to die sooner from a wide variety of acute and chronic conditions. Racial and ethnic minorities receive lower quality of health care compared to whites across a wide range of preventive, diagnostic, and therapeutic services. These conditions in health care contribute to continuing racial-ethnic differences in the burden of illness and death. For example, an estimated 15.8 million people in the United States are living with Coronary Heart Disease (CHD) and more than 5.7 million with the effects of stroke, which is the second leading cause of dementia after Alzheimer's disease (Healthy People 2010 Midcourse Review, 2007). African-Americans continue to experience a higher rate of stroke, have more severe strokes, and continue to be twice as likely to die from stroke as white Americans. Disparities in cardiovascular disease are among the most serious public health problems.

About 70 million Americans fall into the newly recognized blood pressure risk category of “pre hypertension” and are in danger of developing hypertension (high blood pressure) and its associated complications. Hypertension leads to more than half of all heart attacks, strokes, and heart failure cases in the United States each year and increases the risk of kidney failure and blindness. The prevalence of high blood pressure—a major risk factor for coronary heart disease, stroke, kidney disease, and heart failure—is nearly 40 percent greater in African-Americans than in whites. (An estimated 6.4 million African-Americans have hypertension; Mexican-Americans also experience a high prevalence of hypertension (HHS, 2000a, G-2).

The rate of congestive heart failure hospitalizations in black non-Hispanics 64-75 years was more than twice the rate of that for white non-Hispanics. In addition to heart disease disparities, African-Americans are 30 percent more likely to develop cancer and 30 percent more likely than whites to die from it. Hispanics in the U.S. are 50 percent more likely than whites to suffer from diabetes, and the incidence of diabetes among Native Americans is more than twice that for whites. Moreover, African-American and American Indian infant mortality rates are 2.5 and 1.5 times higher, respectively, than that of whites.

Causes of Health Disparities

The cause of health disparities is certainly multi-factorial. It is related to the interplay between individual/personal factors, socioeconomic, neighborhood/environmental, institutional and other social determinants of health that occur in certain sub populations.

Individual factors. Individual factors include behavior, language, literacy, poverty, low education, lack of health insurance or under insurance, and or lack of a regular source of care.

System factors. System factors that can contribute to health care disparities include limited clinic hours and lack of availability of cultural and linguistic appropriate materials. These factors can contribute to patient dissatisfaction, poor comprehension, compliance, and low quality of care.

Disparities in health care have significant implications for health professionals, administration, policymakers, and health care consumers and present a significant challenge to the health system. Strategies to eliminate health care disparities will require intervening on multiple levels within the various factors that contribute to disparities.

Individual level changes include improving knowledge and awareness of diseases, changing behavior related to smoking, exercise, nutrition, monitoring blood pressure, and adhering to medical advice. Societal level changes include improving access to quality health care, reducing health care costs, and making health care more affordable for those with low or no income.

Systems level changes include changing the organization of care, improving the degree to which systems are culturally appropriate for patient population being served, providing practice staff with Cultural and Linguistic Competence Training, improving language access

including the availability of interpreters, making changes in the physical environment and diversity in the health professions.

Current Research and Actions to Eliminate Health Care Disparities

Several recent initiatives included under the Recovery Act have potential to affect health care disparities. Among them are:

Evidence-based and Community Based Prevention and Wellness Strategies Recovery Plan. Will help to reduce risk factors and prevent/delay chronic disease, promote wellness, and better manage chronic conditions. This program will deliver specific, measurable health outcomes that address chronic disease rates.

Comparative Effectiveness Research. Includes \$400 million allocated to the Office of the Secretary to conduct a rigorous evaluation of the impact of different options that are available for treating a given medical condition for a particular set of patients. It involves comparing clinical outcomes, effectiveness, and appropriateness of items, services, and procedures to prevent, diagnose, or treat diseases, disorders, and other health conditions.

Several Initiatives currently in place at OMH are also devoted to reducing and eliminating health and health care disparities:

- Strategic Framework for Improving Racial/Ethnic Minority Health and Eliminating Racial/Ethnic Health Disparities
- National Partnership to End Health Disparities
- Federal Collaboration on Health Disparities Research
- Culturally Competence Curriculum Modules (CCCM)
- OMH Grant Programs to Eliminate Health Disparities
- HIV/AIDS Health Improvement for Re-entering Ex-Offenders Initiative (HIRE Program)
- National Health Information Technology Collaborative for the Underserved (NHIT-UP)

The Strategic Framework for Improving Racial/Ethnic Minority Health and Eliminating Racial/Ethnic Health Disparities, developed by OMH, is intended to help guide, organize, and coordinate the systematic planning, implementation, and evaluation of efforts within OMH, HHS and across the nation to achieve better results relative to minority health improvement and health disparity reduction.

The National Partnership to End Health Disparities, created in 2006, provides opportunities for leadership, ownership, and accountability at all levels of involvement, not just within the federal government. NPA was created to work across the country to create a nation free of health disparities, with quality health outcomes for all people. NPA has five action-oriented objectives for ending health disparities; 1) awareness; 2) leadership; 3) health and healthy system experience; 4) cultural and linguistic competency; and 5) research and evaluation.

The Federal Collaboration on Health Disparities Research (FCHDR), led by the HHS Health Disparities Council and the Interagency Committee on Disability Research in the Department of Education, was created to identify and support research priorities for cross-agency collaboration to hasten the elimination of health disparities. FCHDR is currently working on

collaborative research focused on obesity, built environment, co-morbidities, and culturally appropriate mental health care. Seven federal departments and 14 agencies are currently involved.

Culturally Competence Curriculum Modules (CCCM) were specifically designed by OMH to focus on medical providers and to deliver concepts, tools, and case studies that illustrate both the need and the benefit of providing culturally competent care in a clinical setting. CCCM targets client/patient and health care provider knowledge on health disparities, and improvement of health care professional practices and institutional policies that support delivery of care.

OMH Division of Program Operations (DPO) is the focal point within OMH for grant programs eliminate health disparities. It uses various mechanisms to conduct programs that support public and private community-based practices and innovative models to improve information dissemination, education, prevention, and service delivery to minority communities. DPO develops, implements and monitors programs and activities in response to new program direction and policy, and facilitates the involvement of other Department agencies in areas of mutual interest and concern. DPO currently administers a number of grants programs aimed at eliminating disparities.

HIV/AIDS Health Improvement for Re-entering Ex-Offenders Initiative (HIRE Program) is a new initiative created in 2009 to provide access to HIV/AIDS prevention and treatment services to ex-offenders' to ensure their successful transition from state or federal incarceration back to their communities. HIRE focuses on the three states with the highest incidence of inmates known to be infected with HIV or to have confirmed AIDS in state prisons at year end 2006: New York (4,000), Florida (3,412), and Texas (2,693). Through this new initiative, community-based and faith-based organizations will deliver comprehensive HIV/AIDS-related services and transition assistance including prescription drug assistance, substance abuse, and mental health services, and will address ex offender issues related to employment, family, education, housing, and community involvement.

The National Health Information Technology Collaborative for the Underserved (NHIT-UP) is a public/private partnership formed in 2008 to study and propose solutions to reduce and ultimately eliminate health disparities experienced by medically underserved areas and populations through the use of advances in health IT. Activities include convening meetings to discuss advances in the field, documenting models and strategies to inform and engage the underserved in the use of Health Information Technology (HIT) for health self-management and empowerment, and making recommendations on infrastructural and training needs. Health IT applications are expected to lead to a richer set of data from which population health care trends can be assessed. Health IT also enables greater communication between patients and providers and better tracking of care delivered and outcomes achieved. In addition to changes at the multifactorial levels described earlier, workforce diversity will also be key. Despite making up almost 28 percent of the nation's populations, African-Americans, Native Americans, and Latinos make up only 3 percent of the medical school faculty, fewer than 16 percent of public health school faculty, and only 17 percent of all city and county health officers (Collins from Betancourt paper). This lack of diversity is believed to

contribute to structural policies, procedures, and delivery system that are inappropriately designed or poorly suited to serve diverse patient populations.

Ultimately, interdisciplinary approaches carried out collaboratively with all partner sectors will be instrumental to eliminating health care disparities. Such an approach will need to include policy makers, federal, state, and local partners; health care systems, health care professionals, health care professional associations, community based organizations, faith-based institutions, and a broad spectrum of the public.

Strategies and solutions to eliminate health care disparities also will need to be mindful of the socioeconomic inequality, concentrated poverty, inequitable and segregated housing, and education and the role these upstream factors play in health and disease. In the end, issues related to health disparities in racial and ethnic minorities are not a minority problem; it is an American problem and will take the collective efforts of all of us working together to solve these issues and bring true quality health care to all.

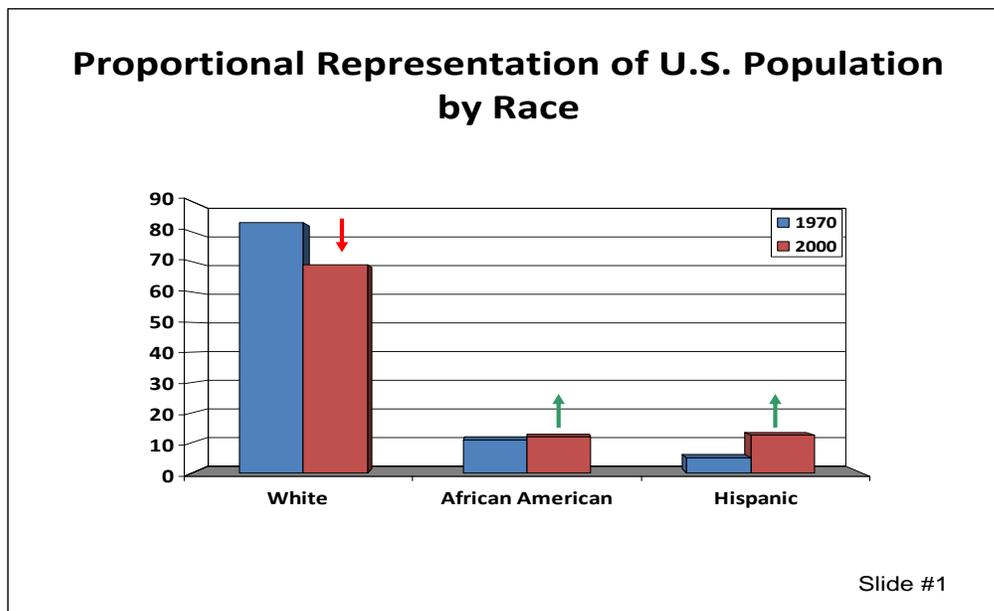
Rubens J. Pamies

Martin Luther King, Jr. once said, “Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”

Greetings. Thank you for the opportunity to speak today about health disparities. I am Rubens Pamies, Vice Chancellor of Academic Affairs and Dean of Graduate Studies and Professor of Internal Medicine at the University of Nebraska Medical Center in Omaha, Nebraska. As a physician and researcher, identifying and addressing health disparities are issues I have studied for over 20 years.

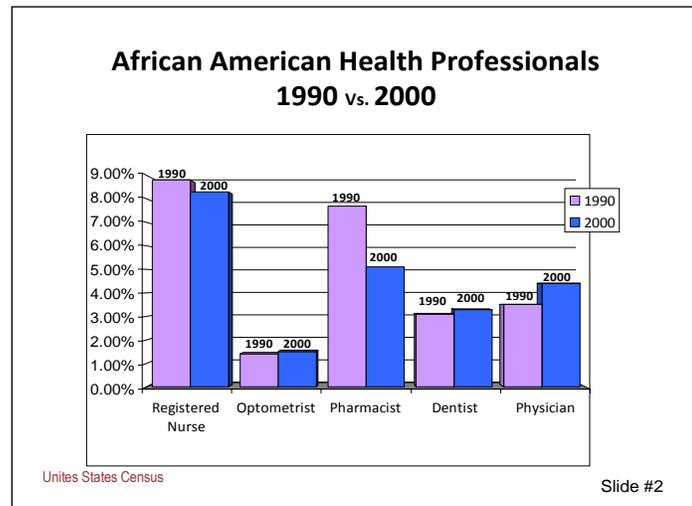
Diversity

To best understand health disparities, it is important to look at the diversity of America. (Slide #1) Over the past 20 years, the proportion of white Americans has decreased from 83 percent in 1970 to 69 percent in 2000, while the proportion of African-Americans has increased slightly from 11 percent to 12 percent, and the proportion of Hispanics jumped from nearly 5 percent to 12.5 percent.¹ Our country is becoming increasingly diverse, making our healthcare issues uniquely different from other comparable nations around the world. The U.S. Census Bureau had originally estimated that by the year 2050, nearly one in two Americans will be a member of a racial or ethnic minority.² Projections indicate this could occur as early as 2037. Currently, four states and the District of Columbia have majority minority populations.³



² *U.S. Interim Projections by Age, Sex, Race, and Hispanic Origin*. Washington, DC: US Census Bureau, Population Division, Population Projections Branch, US Dept of Commerce; 2004. Available at: <http://www.census.gov/ipc/www.usinterimproj/>.

³ U.S. Census Bureau Press Release. Available at: <http://www.census.gov/Press-Release/www/releases/archives/population/013734.html>.



Workforce

Currently, the health care workforce is not representative of minorities in the general population. According to the U.S. Census, Hispanics comprise 12 percent of the population, but only 2 percent of registered nurses, 3.4 percent of psychologists, and 3.5 percent of physicians.⁴ Similarly, African-Americans constituted 12 percent of the total population in 2000, but only 5 percent of physicians, 9 percent of registered nurses, and 4 percent of dentists.⁵ (Slide #2) In the last 10 years, the percentage of African-Americans in health care careers has actually dropped in nursing and pharmacy, while slight increases were seen in optometry, dentistry and physicians. (Slide #3) In total, underrepresented minorities comprise less than 8 percent of physicians nationwide, and only 4 percent of medical school faculty, with almost 20 percent of these minority faculty coming from Historically Black Colleges and Universities.⁶

Proportional representation is important for a variety of reasons, not only for patient care, but also for showing underrepresented students they can enter healthcare fields, and for enhancing the cultural competency and learning environment in the workforce. A landmark Institute of Medicine Report, entitled, “*Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*,” articulated the need for increasing diversity in healthcare. The report drew four conclusions. First, underrepresented minority health care professionals are significantly more likely to serve in medically underserved communities, which often include urban and disadvantaged areas.⁷ Second, studies have shown that patients are more likely to seek care from a physician of their own race or ethnicity and report being more satisfied when doing so. Third, minorities considering health care professions are more likely to

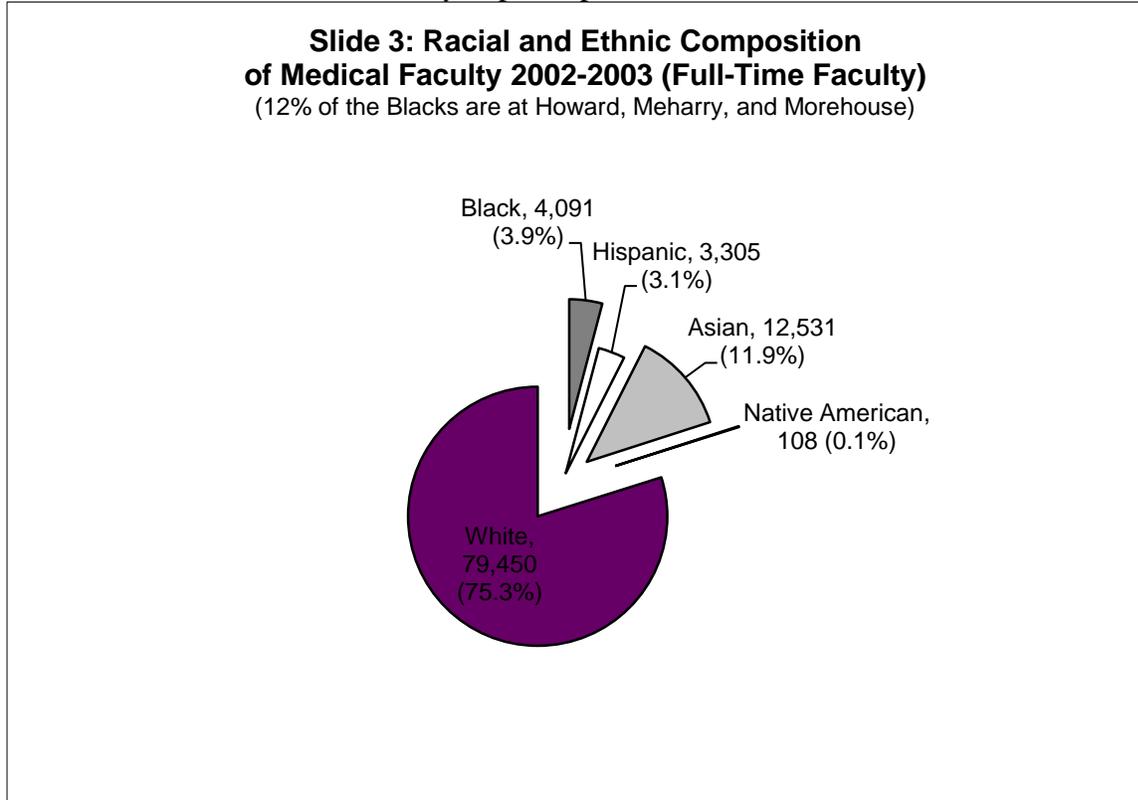
⁴ US Census Bureau, EEO Tool. Employment by Occupation, Sex, Age, and Race for U.S. Total. Available at: <http://www.census.gov/eo2000/index.html>.

⁵ *Id.*

⁶ Association of American Medical Colleges, Faculty Roster System. Available at: <http://www.aamc.org/data/facultyroster/usmsf03/start.htm>.

⁷ Satcher & Pamies, *supra* at 406.

pursue fields where they see minority role models.⁸ The final reason concerns medical research. Minorities are more likely to participate in research studies when the research is



conducted by a health care provider of the same minority group.⁹ Consequently, underrepresented minority health care professionals are more likely to have research interest in diseases which disproportionately affect minority patient populations, thereby helping to solve the mysteries regarding why certain conditions disproportionately produce poorer outcomes for minorities. Because these researchers often see first-hand the effects of various diseases on their communities and families, they become interested in learning more about the disease and dedicate their professional careers to treatment solutions. Clinical research studies are vital to understanding why certain racial and ethnic groups are affected differently by diseases and treatments. It is essential that data related to minority health care continue to be collected.

Mortality, Morbidity and Disease Incidence

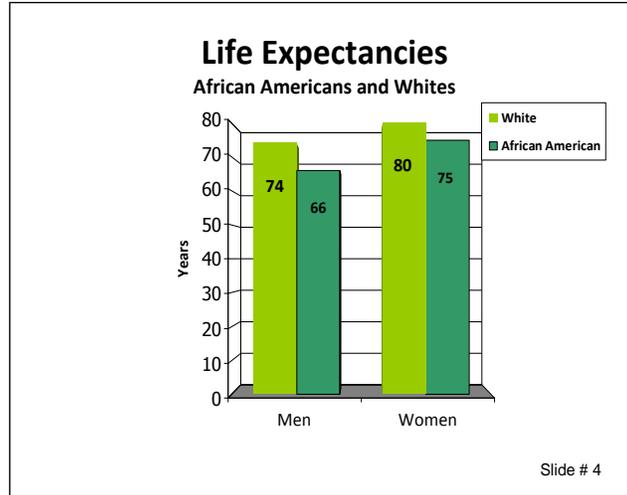
It has been said that the U.S. health care system is wonderful if you are healthy. Unfortunately, that is not the case for many individuals. Despite overall health improvements in the U.S. population, racial and ethnic minorities experience higher rates of morbidity and mortality than non-minorities.¹⁰ This point is proven simply by looking at life expectancies. (Slide #4) African-American men have a shorter life expectancy at 66 years than white men, who, on average, live until age 74. Compare that with American Indian men, who in some areas can only expect to live into their mid-50s. While life expectancies for most groups have

⁸ *Id.*

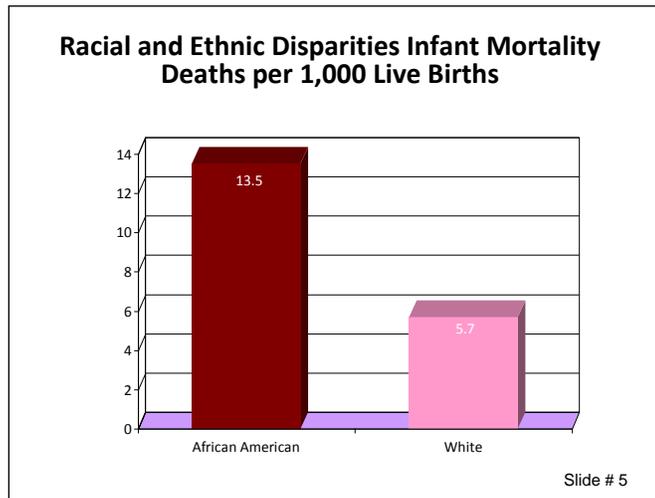
⁹ *Id.*

¹⁰ *Id.* at 3.

risen, the life expectancy gap between white and African-American males has not changed significantly in 40 years. Even though our country can tout major health and technological advances in the last 60 years, African-Americans' mortality rate -- at 1.6 times higher than



whites -- is identical to the ratio in 1950. (Slide #5) Infant mortality rates are just as dismal as rates for African-Americans and American Indians are 2.5 and 1.5 times higher than whites.¹¹



Examining the prevalence of certain diseases and conditions in racial and ethnic minorities reveals further evidence of health disparities. African-Americans have the highest rates of mortality from heart disease, cancer, cerebrovascular disease, and HIV/AIDS than any other U.S. racial/ethnic group.¹² In fact, the HIV rate is reaching epidemic levels, particularly for African-American females. More than 80 percent of women who have HIV and AIDS are

¹¹ *Id* at 10-12.

¹² Institute of Medicine of the National Academies, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* 29 (2003).

either African-American or Hispanic.¹³ American Indians have higher rates of diabetes and liver disease, and Hispanics are more likely than whites to die from diabetes, which modern medicine has made increasingly manageable. Asian-American subpopulations experience rates of stomach, liver and cervical cancers that are well above national averages.¹⁴

The disparate burden of cardiovascular and hypertensive disease is particularly concerning. Hypertension in African-Americans leads to an 80 percent higher stroke mortality rate, a 50 percent higher heart disease mortality rate, and a 32 percent higher rate of renal disease than the general population.¹⁵ Half of African-Americans aged 40 through 59 are hypertensive compared with 30 percent of whites.¹⁶ Initially, access to care was suspected as the primary cause. However, even in Veterans Affairs hospitals, where access is not an issue, major health disparities still exist. Studies there have shown that physicians are less likely to refer African-American patients for cardiac catheterization, and African-Americans are less likely to undergo invasive cardiac procedures.¹⁷ Current theories on cardiovascular health disparities center on a variety of factors, including racial discrimination in treatment, genetics, environment, and demographics.¹⁸

There are new theories emerging about the burgeoning cardiovascular health disparities affecting African-Americans in greater numbers than any other race. The first theory is epigenetics, or changes to the DNA caused by environmental agents such as diet or stress, that can actually be passed on from one generation to the next. Epigenetics underscores the cumulative effects of poor socioeconomic conditions, discrimination, and inequality in education and other opportunities. The second theory is the Allostatic Load, which declares that the body experiences biological changes in response to stress. Specifically, cortisol releasing hormones are higher in those that have experienced prolonged stress, suggesting that years of feeling unequal or experiencing discrimination can worsen cardiovascular health.

The current economic situation has resulted in reports that fewer prescription drugs are being refilled. The concern is that individuals who have been successful at maintaining healthy blood pressures and other cardiovascular conditions with medication may no longer be able to afford them, which will result in higher blood pressures, increased stress and hypertension, and a number of other dangerous conditions. We may see a shift from health maintenance with medications at a modest cost to emergency room treatment at a much higher cost.

Causes of Health Disparities

The disproportionate burden of health disparities has been well documented in the United States for the last two centuries. There are several contributing factors, including socioeconomics, racism and discrimination, limited access to health care, the quality of services provided, patient and provider behavioral factors, as well as many others. These

¹³ U.S. Center for Disease Control, Available at: <http://www.cdc.gov/hiv/topics/surveillance/resources/slides/women/slides/Women.pdf>

¹⁴ Satcher & Pamies, *supra* at 10-12, 209-210.

¹⁵ *Id* at 168.

¹⁶ *Id* at 167.

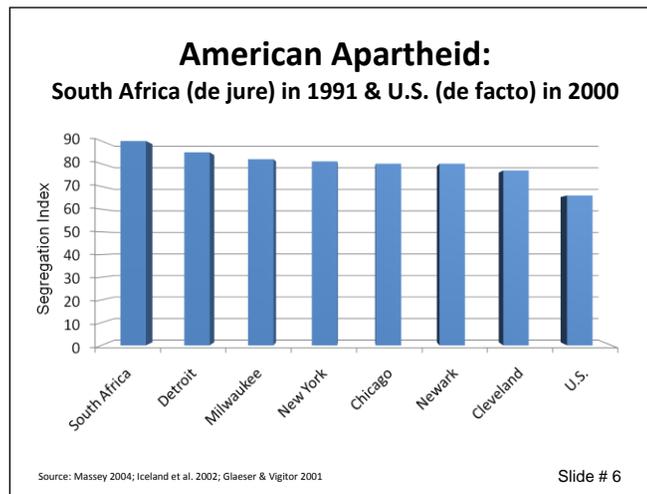
¹⁷ *Id* at 169.

¹⁸ *Id* at 170.

factors tend to compound one another and create a cycle of problems. Despite increases in access to care and immunizations, the differences between many minority groups compared to whites are either stagnant or getting worse.

Socioeconomics

Being in a lower socioeconomic class usually means having substandard housing conditions, fewer opportunities for higher education, less health insurance coverage, and limited access to health care.¹⁹ The environmental health risks, which include everything from air and water quality to soil contaminants and other pollutants, tend to be more prevalent in low-income communities. Lower socioeconomic groups often live in more segregated areas, where there are higher poverty levels and more drug and alcohol abuse. Missing from these environments are: green space, access to healthy foods, job opportunities, and access to healthcare. More than any other racial group, African-Americans tend to live in segregated neighborhoods. (Slide #6) In fact, some major urban areas of the United States are as segregated as apartheid-era South Africa.²⁰ In 2000, an index measuring black and white housing segregation showed that two-thirds of African-Americans would have to relocate in order to achieve a statistically random distribution of black and white households in America. Individuals living in segregated areas typically do not have the resources to transfer wealth to the next generation; instead, kids inherit a lifetime of poverty, a lack of educational opportunities, and typically a lifetime of poor health.



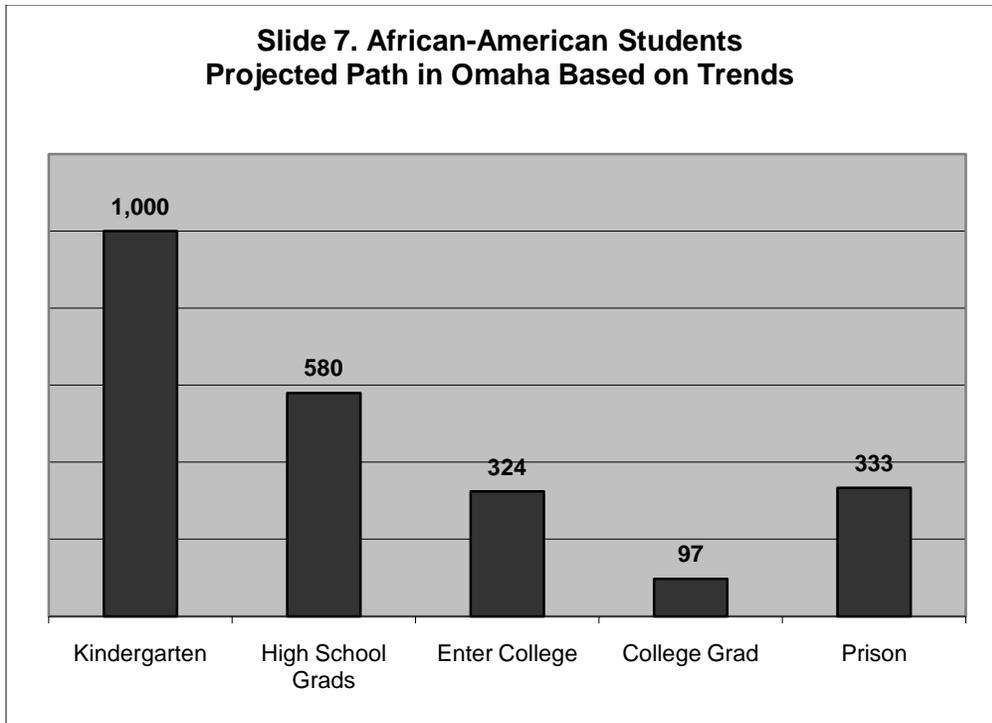
Educational Inequality

Low-income, segregated areas of communities have a lower tax base and less philanthropic ability to support education. As a result, racial and ethnic minorities have fewer educational opportunities, and fewer role models, and they tend to limit their goals to low-paying and in some cases hazardous occupations. For many minority children, others' expectations of them are set so low, they never reach their full potential.

¹⁹ *Id* at 18.

²⁰ Douglas Massey & Nancy Denton, *American Apartheid: Segregation and the Making of the Underclass*. (1998).

For these children, achieving the American dream is not even a dream. (Slide #7) To illustrate this point, consider 1,000 African-American students starting kindergarten. Of those 1,000 students, over half (580) will graduate from high school. Of those, slightly more than



half will enter college. Seventy percent of those who enter college will drop out before finishing, leaving less than 10% who actually graduate from college. Three times as many who graduate from college will enter prison.

The inequalities in science education programs serve as barriers that prevent minority students from considering health care careers. Additionally, daily headlines announcing an end to affirmative action programs may also play a role in discouraging prospective students from pursuing a health care career. Other obstacles include: fewer pipeline programs that encourage professional careers, financial disadvantages, standardized admissions tests and higher education admissions policies.

Limited Access to Care

Racial and ethnic minorities are less likely to have health insurance,²¹ and those that do often face high copayments and transportation accessibility issues to the local clinic or hospital. There are fewer minority primary care physicians in neighborhoods where minorities reside, resulting in individuals being forced to take more time off of work and to find transportation to and from the health care facility that is usually farther away. When health care is received, it is often reactive rather than preventative, fragmented and uncoordinated, so the health conditions are more chronic and take more time, money and resources to treat. Individuals without health insurance have more difficulty getting appropriate care, as low provider

²¹ Satcher and Pamies, *supra* at 21.

reimbursements have reduced the number of physicians willing to serve low-income populations.

Quality of Services

Studies conclude that racial and ethnic minorities receive a lower quality of health care and diagnostic services than non-minorities.²² Even at equivalent levels of access to care, racial and ethnic minorities are less likely to receive routine medical procedures than white Americans. For example, African-Americans with advanced renal disease are less likely to receive dialysis and kidney transplantation.²³ Similarly, one study found that blacks, African-Americans and Hispanics with bone fractures seen in emergency rooms were less likely than whites to receive pain control medications.²⁴ Lower quality of services can be attributed to provider bias, prejudice, and stereotypes, language barriers, and cultural ineptitude. Providers may make assumptions about the type of treatment or medication patients can afford, and may even provide fewer services to patients based on their insurance plan or ability to pay. This causes stress, which can intensify other health problems. Providers and patients must also address the language barrier, as many minorities live in linguistically-isolated households where no one speaks or understands English proficiently. As a result, many patients do not understand their diagnosis, medications, and plans for follow-up care, which are critically important to improving health.

Patient Variables

While there are external factors that influence health disparities, patients play a major role as well. Studies show that minority patients are more likely to refuse recommended services, adhere poorly to treatment regimens, and delay seeking care. Health literacy continues to be a concern with minority patients. Patients may not understand provider instructions, further complicating or prolonging their recovery. Lastly, based on past experiences, patients may have a general mistrust of health care providers and the medical establishment, making them unwilling to seek timely treatment.

Healthcare Reform

As the U.S. Congress crafts a health care plan, now is an appropriate time to begin addressing the barriers and disparities that exist in health care. Minorities would be best served by the creation of subcommittees to address disparities in health care and workforce diversity. As many studies have demonstrated, more progress needs to be made in attracting minorities to health care professions. The health care workforce must be representative and reflective of the communities served. Health care reform should also include more K-12 science programs in minority-populated areas, which will prepare our youth to consider health care careers. Lastly, comprehensive recommendations to improve housing, green space, poverty conditions and the educational system in urban areas are needed to remove barriers for minority students considering health care careers.

It is undeniable that socioeconomic factors contribute to health disparities. A comprehensive health care reform plan must address these social and environmental factors. Policies should

²² *Id* at 21-22.

²³ MMHD 16

²⁴ *Id*.

address providing adequate primary care, health education and preventative care for healthy lifestyles, which will all help control costs. The cumulative effect of unhealthy behaviors and unsafe living environments is poor health outcomes and higher costs.

Another important inclusion is the creation and support of an electronic health record. This will enable clinics and hospitals to have instant access to patient records, medical histories, and insurance information, all of which are important to ensure a seamless continuum of care. Since many vulnerable populations tend to use emergency rooms or community health clinics rather than primary care physicians for routine care, it is essential to electronically link these entities into the system to improve coordination of care. Electronic health records should promote quality assurance, and the data extracted from them is vital to effectively identify and address health disparities.

Another important step to reducing health disparities is to require employers to provide employees paid time off for health-related appointments. Many workers fear they will lose their jobs if they miss work. Sick workers reduce productivity as they infect others, do not receive critical preventative care and treatment, and their illnesses escalate in severity. Providing paid time off reduces the cost to insurance providers and the health care system.

Based on the Institute of Medicine Report highlighting provider bias and differences in treatment options offered to minority patients, and given that the U.S. population is becoming more diverse, it is critical that health care workers receive additional cultural competency training. This will improve health care providers' ability to understand cultural differences and beliefs in treatment options, help them become more comfortable working with medical translators and increase the quality of care for vulnerable patients.

Many federal programs and initiatives have increased awareness of health disparities, but more can and should be done. America would benefit by the formation of a federal commission on health disparities, which could develop and analyze recommendations for improving the health of racial and ethnic minorities.

Conclusion

The health disparities in America are clear. Large gaps in life expectancies exist; infant mortality rates remain too high; and some statistics, such as the African-American/white mortality ratio, have not improved in 60 years. Many minorities face several issues affecting their health including living in unhealthy environments with fewer health care facilities, fewer health care professionals and less emphasis on general wellness.

As the Institute of Medicine study concluded, people tend to seek treatment from physicians who most resemble them. Increasing minority physicians and faculty members will address the health care workforce shortages and will reduce health care costs if more minorities seek care. Putting more emphasis on cultural competency will improve healthcare quality.

I'd like to conclude with an appropriate quote that says, "In the end, it's not what we don't know that will destroy us, but rather the failure to respond appropriately to what we do know." Thank you.

Amitabh Chandra

My name is Amitabh Chandra, and I am a professor at Harvard University's Kennedy School of Government and a fellow with the Dartmouth Institute for Health Policy. Thank you for inviting me to the Commission to discuss the role of healthcare providers in racial and ethnic disparities in healthcare. (Note: I acknowledge support from National Institute of Aging P01 AG19783 - 02. This briefing draws from my article "Who you are and where you Live: Race and the Geography of Healthcare" *Medical Care* 47(2), February 2009.)

We are all aware of the stubborn persistence of racial disparities in treatment over time, even in the fully insured Medicare population.²⁵ What explains this phenomenon? Unequal Treatment, the Institute of Medicine's encyclopedic survey of these disparities, offers several explanations -- differences in socioeconomic status, patient behaviors, provider quality, and differential treatment of minority patients in the clinical encounter.²⁶ Many advocates believe that the most odious of these, differential treatment in the clinical encounter, is also the most pernicious source of treatment disparities. My first point this morning is that we are unlikely to make great strides in improving minority health by prioritizing action on this channel. Its importance is dominated by other shortcomings, which are far more injurious to minority health.

That racial disparities in health care emanate principally from the clinical encounter embodies the idea that a provider treats two identical patients, one white and the other black, differently. More precisely, treatment differences in the clinical encounter may occur because there is explicit discrimination where a provider consciously withholds valuable care from minority patients. This is the most malfeasant of explanations for disparities in the clinical encounter, and is perhaps one reason for why there is so much interest in this mechanism. But disparities may arise from implicit discrimination, where a harried provider operating in a time-sensitive environment makes unconscious mental decisions that are detrimental to minorities. Stereotyping is the one manifestation of this indiscretion and it occurs when a provider uses a patient's race to deduce information about the benefit of treatment. If African-American patients are on average less likely to be compliant, then a physician may assume that her African-American patient is less compliant. Such reasoning will worsen outcomes for that patient if he is different from the typical African-American, and worsen outcomes for all African-Americans if the stereotype about them is wrong. Such biases are compounded by poor communication between providers and their patients, which may create enormous psychological barriers to minority patients seeking care. Finally, there may be genetic or physiological differences between patients that affect the benefit of treatment by race. My training as an economist precludes me from commenting on the magnitude of this channel, and I will leave it to others to discuss its relevance.

Have we conclusively established the role of the clinical encounter in affecting racial disparities in health care? Answering this simple question carefully poses a formidable

²⁵ Jha A, Fisher ES, Li Z, Orav EJ, Epstein AM. Racial trends in the use of major procedures among the elderly. *New England Journal of Medicine* 2005;353.

²⁶ Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, D.C.: National Academy Press; 2002.

empirical challenge, perhaps one of the greatest empirical challenges in science: we would need to observe the same provider treating two patients with the same economic and social resources, physiology, clinical history, severity, preferences, compliance, and future prognosis. The first problem we confront is that because of patterns of neighborhood segregation, the same provider is rarely observed treating both black and white patients. Ignoring this problem as many researchers have done causes us to attribute differences in neighborhoods, referral patterns, and the quality of providers that serve different communities to the clinical encounter. But differences in provider quality are a distinct explanation from the same provider treating patients differently, and the two explanations require unconnected policy responses. I will return to this point again.

The second challenge to measuring the size of the clinical encounter is that it is difficult, if not impossible, for observational studies to fully adjust for other relevant factors that affect clinical decision making: patient preferences, severity, social support, and potential compliance affect the benefit from treatment and should affect treatment decisions. These variables are routinely observed by providers treating patients but not by social scientists observing providers. The fact that multiple studies all note that minority patients get less care is interpreted by some to be evidence of pervasive bias in the clinical encounter, and by others of pervasive shortcomings in all observational studies to control for the key determinants of treatment that are correlated with race. I reiterate that many of these determinants may not be physiological.

Researchers have made progress on both these challenges: we have measured disparities for treatments where the role of preferences, follow-up care, communication, and physiology should be less relevant—for example, by studying the receipt of beta-blockers or reperfusion within hours of being admitted for a heart attack. But for these treatments, we found no disparities in the clinical encounter—a finding that undermines the primacy of the clinical encounter explanation. We have also used patient actors and Implicit Association Tests (IATs) to evaluate the role of provider prejudice directly. In these more ‘controlled’ environments, physicians and the researchers studying them observe the same information. This is an exciting and promising area of research, but its findings still nascent for the purpose of informing policy and legislation. Our ability to generalize from these studies is dependent upon whether the self-selected physicians who participated in these laboratory studies are representative of physicians who take care of minority populations.^{27 28}

The final challenge for the focus on the clinical encounter is that we don’t have a policy lever to eliminate it. One often-touted prescription is to encourage cultural competency training for physicians and expansions in the numbers of minority physicians. But this view is grounded more in hope than science. Direct evidence that such policies will improve minority health care remains absent. In fact, one study in the *New England J. Medicine* found that racial

²⁷ Green, Alexander, Dana Carney, Daniel Pallin, Long Ngo, Kristal Paymond, Lisa Iezzoni, Mahzarin Banaji, “Implicit Bias among Physicians and its Predictions of Thrombolysis for Blacks and Whites Patients,” *Journal of General Internal Medicine*, June 2007.

²⁸ Schulman KA, Berlin JA, Harless W, et al. The effect of race and sex on physicians’ recommendations for cardiac catheterization. *N Engl J Med*. 1999;340(8):618–26.

differences in treatment were similar among patients treated by white and black physicians.²⁹ Indeed, we could even damage minority health further if these interventions alienate or displace the least prejudicial physicians—those who have devoted their lives to treating minority patients.

My second point is to elaborate on how providers influence minority health, but through a different dimension than I have just discussed. A new explanation for racial disparities in care is that they are partially the consequence of differences in where minorities and whites receive care.³⁰ If different providers treat blacks and whites, then perhaps one reason for racial disparities in care is not only who you are—your race—but also where you live.^{31 32} Both sources of disparities are injurious to minority health care. The first type of variation, "within provider variation," highlights the role of explicit and implicit discrimination in the clinical encounter. The second, "between provider variation," relates less to race per se and more to geographical variations in the quality of treatment patterns of all patients.^{33 34} It contributes to racial disparities in treatment because minorities are more likely to be cared for by lower quality providers. (Some large academic centers are an exception to this statement, but the link between such centers and quality is by no means automatic.)³⁵ Differences in where minorities are treated have to do with factors such as lower socio-economic status, but historical patterns of discrimination and neighborhood segregation surely exacerbate this variation.^{36 37} Confronted with these realities, we should be cautious in concluding that malfeasance and nonfeasance are the sole purview of the medical profession.

So what is the evidence in favor of the role of geography as a determinant of racial disparities in health care? Peter Bach and his colleagues has demonstrated that blacks and whites have different providers, and those providers who treat minorities are often less clinically trained and have fewer resources.³⁸ This finding challenges much of the emphasis on the individual

²⁹ Chen J, Rathore SS, Radford MJ, Wang Y, Krumholz HM. Racial difference in the use of cardiac catheterization after acute myocardial infarction. *N Engl J Med* 2001;344:1443 - 1449.

³⁰ Wennberg JE, Cooper MM. eds., *The Dartmouth Atlas of Health Care 1999* (Chicago: American Hospital Association, 1999).

³¹ Skinner J, Weinstein JN, Sporer SM, Wennberg JE. Racial, ethnic, and geographic disparities in rates of knee arthroplasty among Medicare patients. *N Engl J Med* 2003;349:1350 - 9.

³² Chandra A, Skinner J. Geography and Health Disparities. In: Anderson NB, Bulatao R, Cohen B, eds. *Critical Perspectives on Racial and Ethnic Differences in Health in Late Life*. Washington D.C.: National Research Council of the National Academies; 2004.

³³ Baicker K, Chandra A, Skinner JS. Geographic variation in health care and the problem of measuring racial disparities. *Perspectives in biology and medicine* 2005;48:S42 - 53.

³⁴ Baicker K, Chandra A, Skinner JS, Wennberg JE. Who you are and where you live: how race and geography affect the treatment of Medicare beneficiaries. *Health affairs (Project Hope)* 2004;Suppl Web Exclusives: 33 - 44.

³⁵ Yasaitis, Laura, Elliott S. Fisher, Jonathan S. Skinner, and Amitabh Chandra. Hospital Quality And Intensity Of Spending: Is There An Association? *Health Affairs Web Exclusive*, May 21, 2009.

³⁶ Williams DR, Collins C. Racial residential segregation: a fundamental cause of racial disparities in health. *Public Health Rep.* 2001 Sep–Oct; 116(5): 404–416.

³⁷ Williams DR, Jackson PB. Social Sources Of Racial Disparities In Health. *Health Affairs*, March/April 2005; 24(2): 325 - 334.

³⁸ Bach PB, Pham HH, Schrag D, Tate RC, Hargraves JL. Primary care physicians who treat blacks and whites. *N Engl J Med* 2004;351:575 - 84.

clinical encounter, for key to that argument is the requirement that the same provider treats minority and majority patients differently. To understand the geography explanation further, consider how segregated the treatment of heart attacks is today: My collaborators and I have demonstrated that 85 percent of all black heart attack patients are treated by only 1,000 hospitals.³⁹ By contrast, 60 percent of whites receive their care in hospitals that treat no black heart attack patients. Because blacks and whites go to different hospitals for AMI care, differences across hospital in their ability to provide rapid reperfusion will play an important role in observed racial disparities in outcomes for heart attacks. Within hospitals, we found that there were no black–white disparities in the use of effective medical treatments such as aspirin and beta-blockers during hospitalization. But there were substantial racial differences in treatments if one ignored where one was treated. In other work we found that AMI patients admitted to hospitals that disproportionately served blacks have been found to experience a risk-adjusted 90-day mortality rate that is almost 40 percent higher than that of non-minority serving hospitals.⁴⁰ These patients had similar co-morbidities and disease severity, suggesting that the difference in survival may be attributed to differences in the quality of treatment. For heart attack treatments, over half of the gap in survival can be explained by differences in where patients received care. Others have noted similar findings for the performance of NICUs in minority serving hospitals.⁴¹ Forty years after the passage of Civil Rights Act, minority health care is de facto separate and unequal. Ironically, a close cousin of this embarrassment, segregated hospitals, was the original motivation for Title VI legislation.

The new focus on the geography of minority health care should not be viewed as taking attention away from reforming the clinical encounter. Rather, it notes that even if we could fully eliminate disparities in the clinical encounter, the health care of blacks would improve but still lag behind that of whites because of differences in the quality of where the two groups receive care. For many of us, this is simply not good enough. I believe that we can do better, much better. In the context of ambulatory diabetes care, my collaborators at Dartmouth and I estimate that aggressively improving the performance of the 500 largest minority serving networks would improve minority health care more than the complete elimination of racial disparities within every provider in the U.S. Because a small group of providers treat minority patients, targeting quality improvements towards minority serving providers will dramatically reduce black-white disparities in care more generally. Such interventions would improve the health of both minority and white patients, but the gains would disproportionately accrue to minority patients whose care is concentrated in such providers. Indeed, given the greater reliance on ambulatory care, one may want to think about expanding the reach of Title VI of Civil Rights legislation to go beyond the reach of hospital care and encompass care that is delivered in office visits and by managed care plans.

³⁹ Barnato AE, Lucas FL, Staiger D, Wennberg DE, Chandra A. Hospital - level Racial Disparities in Acute Myocardial Infarction Treatment and Outcomes. *Med Care*. 2005;43(4):308 - 19.

⁴⁰ Skinner J, Chandra A, Staiger D, Lee J, McClellan M. Mortality After Acute Myocardial Infarction in Hospitals That Disproportionately Treat Black Patients. *Circulation*. 2005;112(17):2634 - 2641.

⁴¹ Morales, Leo S., Staiger, Douglas, Horbar, Jeffrey D., Carpenter, Joseph, Kenny, Michael, Geppert, Jeffrey, Rogowski, Jeannette. Mortality Among Very Low - Birthweight Infants in Hospitals Serving Minority Populations. *Am J Public Health* 2005 95: 2206 - 2212.

Finally, in closing let me make one simple point: the determinants of racial disparities in health are not the same as the determinants of disparities in health care. The principal determinants of health are genes, behaviors, schooling, neighborhoods, and economic circumstance. Health is secondarily affected by health care, but more likely to be influenced by prevention including the quality of ambulatory care, which can check the progression of diabetes, hypertension and chronic disease, and through this protection, the incidence of heart attacks and strokes. Of tertiary importance, at the very end of the causal chain is the role of disparities in the care encounter; the quality of that encounter matters much more than the disparity within it. So the 6.5 year racial gap in life expectancy for men and the 4.5 year racial gap for women, which are surely larger when one accounts for the condition of that life, are unlikely to be affected by the focus on treatment disparities.⁴² The preoccupation with treatment disparities in the endgame misses the fact that minority patients find themselves confronting the endgame sooner and more often than anyone else.

⁴² Harper, Sam, John Lynch; Scott Burris; George Davey Smith. Trends in the Black - White Life Expectancy Gap in the United States, 1983 - 2003. JAMA. 2007;297(11):1224 - 1232.

Sally L. Satel

Chairman Reynolds, Vice-Chairman Thernstrom, and other esteemed members of the Commission, thank you for the invitation to address you on the nature of health disparities.

My name is Sally Satel. I am a resident scholar at the American Enterprise Institute and a physician practicing part time at a local methadone clinic. At AEI, much of my work has focused on the interface of medicine and culture and the politicization of science. I have been particularly interested in the manifestation of identity politics within medicine. Until several years ago, the subject of health disparities has been an exceptionally rich example of this phenomenon.

Today I would like to present an overview of health disparities as a discrete topic within the domain of health policy. I will briefly trace the evolution of the conceptual underpinnings of the health disparities issue from its origins as an epidemiological phenomenon with no posited cause, to a civil rights problem presumably driven by bias among physicians, and then to a public health concern stemming from socio-economic factors. Unsurprising, as the causal orientation shifts from civil rights to public health, proposed remedies must realign as well. The themes in this statement are elaborated in greater depth in *The Health Disparities Myth – Closing the Treatment Gap* (AEI Press 2006) which has been distributed to all members of the Commission and is available online at: http://www.aei.org/docLib/20080630_HealthDisparitiesMyth.pdf.

Health Disparities Emerges as a Policy Issue

One of the earliest appearances of the term “health disparity” was in the 1985 *Report of the Secretary’s Task Force on Black and Minority Health*, published by the U.S. Department of Health, Education, and Welfare (now HHS). There the term referred to “excess deaths”—that is, the difference between the number of deaths observed in a racial/ethnic group and the number of deaths that would have occurred in that group if it had the same death rate as the non-Hispanic white population. This definition of “disparity” was purely descriptive; it was silent on the question of what *produces* these differences.

In 1999, the National Institutes of Health devised a similar definition of health disparities: “Differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.” Similarly agnostic definitions have been issued by other government agencies and offices.

Although allusions to “racism” in the health care system had been made during the 1990s, the idea was catapulted into public consciousness by a much-cited 2002 report from the Institute of Medicine (IOM), part of the National Academy of Sciences, called *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. The report defined disparities as, “racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences and appropriateness of intervention.”⁴³ Emphasis was placed on the doctor-patient relationship, which, the report said, is marked by “bias,”

⁴³ Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. 4. (Washington, D.C.: National Academy of Sciences, 2002)

“prejudice,” and “discrimination.” The report claimed that the clinical encounter itself – more specifically, the inferior treatment that white doctors gave minority patients -- fueled the treatment differential and, by extension, the poorer health of minorities.

Media coverage of the IOM report was extensive and sensational: “Color-Blind Care . . . Is Not What Minorities Are Getting” (*Newsday*); “Fed Report Cites ‘Prejudice’ in White, Minority Health Care Gap” (*Boston Herald*); and “Separate and Unequal” (*St. Louis Post-Dispatch*). The IOM report was a watershed event. It transformed the concept of “disparity” from an epidemiological phenomenon into a civil rights matter. The word *disparity* now connoted unfair difference due to a patient’s race or ethnicity. As epidemiologist Olivia Carter-Pokras at the University of Maryland observed, the word *disparity* “has begun to take on the implication of injustice.” Accordingly, remedies proposed by the IOM experts and others have emphasized race-based prescriptions -- most prominently, workforce diversity initiatives and cultural competence training. I will begin by focusing on the questionable rationales behind these initiatives.

Assumptions of the Health Disparities Project

Three bedrock assumptions of the health disparities project warrant mention.

Assumption #1: “Bias” Can Be Proven

A key premise of disparities research is that the existence of bias can be established through retrospective research. Yet the myriad factors that contribute to doctors’ thinking cannot be inferred from large databases. Nuanced research on physician behavior requires prospective work conducted in the clinical setting; it cannot be divined from after-the-fact inferences about how doctors behave or sterile questionnaires that do not (cannot) capture the complexity of the clinical decision-making process. Quantitatively trained sociologists would need to play a larger role in these investigations.

Assumption #2: Measuring the Relative Health of Groups Is an Optimal Strategy

The health disparities project is concerned primarily with relative health. A fundamental research query is whether certain ethnic groups are receiving more or less health care than other groups. While this approach may have an intuitive appeal, it is problematic for several reasons and should thus be only one of many metrics for measuring improvement in minority health.

First, it can mask absolute improvements in care.⁴⁴ Consider this illustrative example:

Black patients with diabetes who attended a Bronx clinic were tested for diabetic control 53 percent of the time; whites were tested 57 percent of the time. This difference of four percentage points was smaller than the testing differential of 14 percentage points found at a Washington, D.C., clinic. The smaller gap could be seen as indicative of a better overall situation. But a closer look shows that 59 percent of blacks in the Washington clinic were tested, versus 73 percent of whites.

⁴⁴ David Mechanic, “Policy Challenges in Addressing Racial Disparities and Improving Population Health,” *Health Affairs* 24, no. 2 (2005): 336.

In absolute terms, the D.C. diabetics—both black and white—received better care than their Bronx counterparts, but a narrow judgment based on racial comparison alone would conceal this reality. Indeed, absolute improvements in treatment—if they occur in all groups—will not close a gap but should still be recognized as valuable.

Second, focusing on narrowing disparities can obscure deficiencies in care.

Amal Trivedi and colleagues at Harvard found greater improvements in black patients than whites in the receipt of necessary tests and treatments (for example, eye exams for diabetics or beta-blockers after heart attacks) over a six-year period. Just looking at the narrowed black-white differentials would conceal the fact that both white and black patients, all of whom were enrolled in Medicare managed-care plans, received the tests with sub-optimal regularity.

Assumption #3: Health Gaps Can Be Closed

Pragmatically, it will be impossible to eliminate health differences without first eliminating the other disparities in society (e.g., early education, family stability, income, and so on) that are linked with health status. Though some public health experts would argue otherwise, reorganizing the socioeconomic sphere of our nation is a mission that transcends the purview of the public health profession. The questions about societal leveling: how to execute it; whether to pursue it at all and, if so, in which domains -- are best left to politicians, voters, and social welfare policy experts. Nonetheless, if eliminating disparities is the goal of the health disparities project, it will be an elusive one indeed.

Do Minority Patients Fare Better with Minority Physicians?

Considerable emphasis is placed on the importance of physician workforce diversity (based upon the notion that race concordance between patient and doctor will improve minority health) and cultural competence training as ways to close the health gap. This contention has weak empirical basis, however. Perhaps more data will prove their virtues, but at present, they seem driven more by intuition than fact.

Do the data support the claims that minority patients fare better with physicians of their own race?

Only a handful of studies have been devoted to the question of whether patients' outcomes are better if they and their clinicians are of the same race. Some of these were conducted with psychiatric patients, and most showed that clinician race had a minimal impact on how black patients fared in their treatment and recovery. One large study that appeared in the journal *Psychiatric Services* involved more than 1,700 homeless individuals participating in an intensive services program. Each person was randomly assigned a case manager with whom he worked closely. Over the course of a year, improvement in dimensions like the number of days a patient worked at a job, whether he had drug problems, and the number of days he spent homeless bore no relationship to whether he and the case manager were of the same race. A 2005 study from the University of North Carolina found that physician race had little effect on the successful management of high blood pressure in elderly black and white patients. Seeing the same physician, however, was a key factor in attaining good outcomes.

What do patients want?

A comprehensive review of the literature published in the *Journal of Health Politics, Policy and Law* found that “racial/ethnic concordance holds little salience in the minds of most black and Latino patients and that discordance has little effect.”⁴⁵ This is consistent with a poll of 4,000 respondents published by The Commonwealth Fund – one of the largest, most detailed and most ethnically diverse surveys ever conducted. In that survey, the main complaint of almost every patient, regardless of ethnic or racial group, was the doctor’s “failure to spend enough time with me.” When asked to cite the factors that “influence your choice of doctor,” the physician’s “nationality/race/ethnicity” ranked 12th out of 13 possible options.

Other data reinforce the importance of adequate physician-patient contact. A number of studies show that patients report having more say in their treatment (and, presumably, have better compliance with treatment although the studies did not address that question) when the doctor, regardless of race, spent more time with them. A study by Lisa Cooper-Patrick and others found that the amount of time the doctor spent with the patient was a stronger determinant of patients’ “participatory” ratings -- indicating patients’ perceptions of how involved they were in treatment decisions -- than was racial concordance. Thus, it appears that the length of doctor-patient contact overwhelms whatever concordance effect may exist in leading to patients’ enhanced sense of participation.

Sherrie Kaplan and her colleagues also observed that the amount of time the patient spent with the doctor helped determine the participation score. In the one study, visits of less than 20 minutes were found to be too brief to involve patients in treatment decisions. In another analysis, physicians who had “high-volume” practices were rated as less participatory than those who saw fewer patients but spent more time with each. Given the value patients place on face-to-face time with their physician, irrespective of the physician’s race, the real problem seems to be that an average primary care visit is 15 minutes for everyone—rather than its being a few minutes shorter for black patients.

It is important to note, however, that the Cooper-Patrick study is widely cited as support for doctor-patient race concordance. But a closer reading is repaid. Cooper-Patrick reported that black patients rated their visits to doctors as more participatory when their doctors were black.⁴⁶ Yet the clinical significance of this is hard to interpret in light of the fact that patients rated their interactions with same-race physicians (a participation score of 62.6 out of a possible 120) as barely different from interactions with different-race physicians (60.4 out of 120). What’s more, when Sherrie Kaplan and her colleagues employed the same survey instrument, they discovered that minority patients who saw minority doctors had *lower* scores on the questions of participation than those who saw white doctors. The small volume of evidence on this topic indicates that race concordance between patient and physician has no reliable relationship to doctor-patient interactions, let alone to the quality of patient care as a function of race.

⁴⁵ Jason Schnittker and Ka Liang, “The Promise and Limits of Racial/Ethnic Concordance in Physician-Patient Interaction,” *Journal of Health Politics, Policy and Law*, 31 (2006): 811-838.

⁴⁶ Lisa Cooper-Patrick and others, “Race, Gender and Partnership in the Patient-Physician Relationship,” *The Journal of the American Medical Association*, 282, no. 6 (1999): 583-89.

The Limits of *Unequal Treatment*

In view of the deference accorded the IOM report, *Unequal Treatment*, as a “landmark” document, it is important to ask whether the evidence put forth by the report justifies its conclusions about the significance of physician bias in generating health differentials.

The *Health Disparities Myth* presents a lengthy critique. (Note that “myth” refers to the allegation of bias as a major cause of disparities, not to the existence of differentials themselves.) Consider one major limitation of the report: the fact that it did not have enough information to rule out other important determinants of treatment differentials between black and white patients.

This is because most of the studies reviewed by the IOM experts were retrospective, relying upon chart review or large Medicare administrative databases that do not capture many variables that influence the type and frequency of care given. As the IOM report itself acknowledged, the more confounding variables were identified, the smaller the differential between whites and minorities became: “Almost all of the studies reviewed here find that as more potentially confounding variables are controlled, the magnitude of racial and ethnic differentials in care decreases.” Some studies were more scrupulous than others in accounting for confounding determinants of treatment, but even so, a treatment differential often remained.

Cardiovascular illness is one of the most commonly studied conditions because it is a major cause of morbidity and mortality among African-Americans. The studies of cardiovascular care described in the IOM report were generally able to account for co-morbid conditions and severity of disease at the time care was sought. But a number of important clinical variables that influence physician decision-making were often missing from administrative databases—for instance, EKG subtleties, position of occlusion in carotid and coronary vessels, coronary ejection fraction, and pulmonary function test performance. Further, variables such as patient preference and enrollment in supplemental insurance (which can influence whether a certain procedure is administered) are rarely recorded.

Moreover—and this is key—the unrecorded variables tend to vary by race and ethnicity. Consider, again, an example from cardiac care. Much evidence and experience confirms that coronary angiograms of black patients often show less anatomical suitability for intervention than in their white counterparts—either lesions in their vessels are too diffuse for angioplasty, or the patients have a higher incidence of normal-appearing vessels—despite the clinical appearance of having suffered acute myocardial infarction (heart attack). An examination of records, therefore, could suggest a racial bias in treatment simply because coronary angiograms are less often given to black patients. Detailed rationales for treatment choices could explain the differential but these nuances are not reliably indicated in the records themselves.

After Unequal Treatment

In the years following the IOM report, a cascade of studies has demonstrated the vital importance of key variables in health differentials. The result has been less overt talk of “racism” and less insistence that the doctor’s office is a particularly promising place to find a significant cause of health differentials. The current view is that wider, systemic factors underlie health differentials. These factors -- the role of geography, hospital quality, and physician quality -- overwhelm the influence of bias, to the extent it meaningfully exists at all, within the clinical encounter.

Geography

Health care varies a great deal depending on where people live, and because blacks are overrepresented in regions of the United States that are burdened with poorer health facilities, disparities are destined to be, at least in part, a function of residence.⁴⁷

Hospital Quality

Minority patients are more likely to receive care in lower-performing hospitals than are white patients. Hospitals that treat greater numbers of minority patients generally offer poorer-quality service than those that treat fewer minorities. Yet, within hospitals, the quality of care is generally comparable between whites and minorities when they are admitted for the same reason or receive the same procedure.⁴⁸

Physician Quality

White and black patients, on average, do not visit the same population of physicians—making the idea of preferential treatment by individual doctors an improbable explanation for disparities. Doctors whom black patients tend to see may not be in a position to provide optimal care. For example, they report having less access to high-quality colleague-specialists, such as cardiologists or gastroenterologists, to whom they could refer their patients, or to nonemergency hospital services, diagnostic imaging, and ancillary services, such as home health aid. In addition, physicians of any race who disproportionately treat black patients are less likely to have passed a demanding certification exam in their specialty than physicians treating white patients.⁴⁹

Identity Politics Linger

The concept of “cultural competence” is fundamental to the health disparities project. Most medical schools have some kind of cultural competency training. New Jersey was the first state to pass a law requiring doctors to receive so-called “cultural competency” training as a

⁴⁷ R. Hasnain-Wynia, DW Baker, D. Nerenz, J. Feinglass, AC Beal, MB Landrum, R. Behal, JS Weissman, “Disparities in health care are driven by where minority patients seek care: Examination of the hospital quality alliance measures.” *Archives of Internal Medicine* 167, no. 12 (2007): 1233-1239; Katherine Baicker, Amitabh Chandra, and Jonathan S. Skinner, “Geographic Variation in Health Care and the Problem of Measuring Racial Disparities,” *Perspectives in Biology and Medicine* 48, no. 1, supp. (2005): S42–53.

⁴⁸ Katherine Baicker and Amitabh Chandra, “Myths and Misconceptions About Health Insurance,” *Health Affairs* 27, no. 6 (2008): w533-w543.

⁴⁹ Peter B. Bach and others, “Primary Care Physicians Who Treat Blacks and Whites,” *New England Journal of Medicine* 351, no. 6 (2004): 575–84; JD Reschovsky, AS O’Malley, “Do Primary Care Physicians Treating Minority Patients Report Problems Delivering High-Quality Care?” *Health Affairs* 23, no. 3 (2008): 222-231 (Web Exclusive).

condition of obtaining or renewing their licenses to practice medicine; California and Washington followed. All major agencies within HHS have offices of minority health that, among other things, champion cultural competence. Over 40 states have an office dedicated to health disparities, minority health, or multicultural health. The Health Equity and Accountability Act of 2007 and the Minority Improvement and Health Disparity Elimination Act (neither has been re-introduced this session) contained ambitious cultural competence initiatives.

But what exactly is cultural competence? Consider the sprawling definition from the Department of Health and Human Services.

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

-- CLAS Standards Report (U.S. Department of Health and Human Services Office of the Secretary, 2000)

In practice, cultural competence refers to a range of interventions. It can include useful, practical accommodations intended to help health providers care for unacculturated or immigrant populations—such as translation services or education of medical staff about local healing customs and commonly used remedies. But it can also entail blatant, patronizing racial sensitivity training. Accordingly, some observers worry that cultural competence could deteriorate into an oversimplified, stereotyped, paint-by numbers affair that purports to teach students and physicians “how to treat” African-Americans, Asians, Latinos, and others. Others recoil at the specter of a clinical milieu in which black patients will be assigned to black doctors, gay patients to gay doctors, and so on.

At its most constructive, cultural competence is a variant of standard training in doctor-patient communication—a course that is required by all medical schools within the first two years of study. Joseph Betancourt, a physician at Harvard Medical School, describes an universal form of cultural competence that has “evolved from the making of assumptions about patients on the basis of their background to the implementation of the principles of patient-centered care, including exploration, empathy, and responsiveness to patients’ needs, values, and preferences.”⁵⁰ In the end, Betancourt is simply describing competent care—one wonders why this requires a separate course.

⁵⁰ Joseph R. Betancourt, “Cultural Competence—Marginal or Mainstream Movement?” *New England Journal of Medicine* 351, no. 10 (2004):953.

Does cultural competence training have any effect on disparities? A literature search revealed no rigorous evaluations of cultural competency training that attempted to answer whether it improves quality of care, let alone reduces disparities.⁵¹

Conclusion

The health disparities discussion has matured over the years as volumes of data on geographical and economic factors accumulate. Though the bias theme lingers in academic quarters it appears to play a much less dominant part in the discussion of minority health than it in the years following the IOM report. This is a welcome development.

Not only are charges of bias divisive, pursuing them as a priority siphons energy and resources from endeavors targeting system factors that are more relevant to improving minority health: expanding access to high-quality care and facilitating changes in individuals' lifestyles and their capacity to manage chronic disease.

From this perspective, proposed race-based remedies for the treatment gap -- such as racial preferences in admission to medical school to increase diversity, and racial sensitivity training for doctors -- become trivial or irrelevant at best, and potentially harmful at worst.

A true public health solution to inadequate care—one that seeks to maximize the health of all Americans—would more properly target all underserved populations, irrespective of group membership. Success would be reflected in the improved health of these communities; and, because many of them happen to comprise large numbers of minorities, racial and ethnic care differentials would diminish as well.

Selected Endnotes (For version of this statement with full citations see sallysatelmd.com)

Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. 4. (Washington, D.C.: National Academy of Sciences, 2002)

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⁵¹ "Does Cultural Competency Training Improve Quality of Care?" *MDNG New Media*, June 11, 2008 http://www.hcplive.com/mdnglive/webexclusives/Cultural_Competency_Training.

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Peter Bach

Chairman Reynolds, Vice-Chairman Thernstrom, and other esteemed members of the Commission.

My name is Peter Bach. I am a physician at Memorial Sloan Kettering cancer center in New York City, where I do health services research. My research discipline uses a hybrid set of techniques from economics, epidemiology and statistics in order to gain a representative understanding of the health care delivery system. For more than a decade one of my main research interests has been in the field of health disparities.

I bring to this hearing a few other relevant pieces of experience. For one, I have served in a number of capacities for the government, both as an external advisor and internally. I served as an advisor to the trans-HHS working group on health disparities - a group that crafted a long set of important recommendations for both research and implementation regarding the reduction of health disparities.

I also served internally as the Senior Adviser to the Administrator of the Centers for Medicare and Medicaid Services. During my time Mark McClellan was the Administrator, and among other duties, he tasked me with helping coordinate and communicate Medicare's activities regarding disparities among our beneficiaries.

Prior to today my work has led to other opportunities to both testify before Congress and to speak with the media regarding the important questions of both the origins and the potential approaches to health disparities.

I would like to express my gratitude for this invitation to speak with you today. I am humbled by the opportunity, and flattered by the notion that I can add to the discussions that you are having. I also want to thank the funders who have supported my and my colleagues' work over the years, including the National Cancer Institute, the National Institute of Aging, The Commonwealth fund, and the Robert Wood Johnson foundation. I also must specifically credit my colleagues Colin Begg and Deborah Schrag at Memorial Sloan-Kettering, and Hoangmai H Pham at the Center for Studying Health System Change. Although my name might appear as the lead author on some of our group's work, it has all been a highly collaborative effort.

I would like to use my time to reflect on some of the work in which I have been involved, and place the findings from it in context. About a decade ago my colleagues and I began to wonder if the higher rates of mortality from cancer seen among blacks when compared to whites could be due to blacks receiving less effective treatments after diagnosis. We knew that higher rates of blacks getting cancer could not explain the gap, because that gap was only 10 percent, while the cancer death rate in blacks was 33 percent higher than it was in whites.

So we chose a single cancer procedure to study - surgery for early stage lung cancer. We focused on this procedure because it treats the number one cancer killer, is enormously

effective, and we knew that in an analysis, it would be relatively easy to determine if a given patient did or did not receive it. In an analysis published in the *New England Journal of Medicine* in 1999 we showed that in Medicare, blacks with a curable diagnosis received this surgery 13 percent less often than whites with the same diagnosis. We showed that this was not due to greater co-morbidity, or even due to poverty. We also showed that we believed that this treatment gap was the explanation for black patients' poorer outcomes.

The study is personally memorable. It was one of the first major analyses published using the NCI's Seer-Medicare database, which has since become a cornerstone of studies of cancer care. It was also one of the few studies that had demonstrated that treatment gaps were important in terms of disease outcomes. That has since been shown in numerous other settings.

We were unable to determine in our study why treatment rates were lower for blacks. Our study wasn't designed with that question in mind, and the data we used was insufficient to address this sort of granular patient level question. Parenthetically, there is nearly always a tradeoff between wishing to have a study that is broadly representative of the population and wanting to have a study that has tremendous detail about each patient or care setting.

Ours used national data covering many years, and tens of thousands of patients, but had little individual level information. Other work in disparities is notably the opposite, sometimes covering just a few patients and doctors in a single practice setting, from which a lot can be learned about that setting, but less about the "universe" of care settings.

The fallout from the publication was educational for me. A number of pundits used our findings as a platform, to decry the health care system as racist, and by extension, doctors as racists. In fact there was a story in the *New York Times Week In Review* about our study titled "Not just another case of health racism."

Too many people concluded too quickly that the explanation for our findings, and many other similar findings, was that doctors discriminated against their minority patients, providing them less good care than their white patients. I noted in an essay in the *New England Journal of Medicine* that the invocation of racism as the cause of treatment disparities moved the problem from one of health care system quality to one of health care provider moral failure.

Our research group saw in some studies the potential for another explanation for treatment gaps. One that, if you will, "blamed" the system rather than the doctor. We hypothesized that a key reason why blacks received lower quality care than whites could be that they went to doctors who, for a variety of reasons, were less able to provide the higher quality care routinely received by whites. This could be the case because the doctors were less well trained, or less well resourced, or simply less knowledgeable.

In 2004 we published a study in the *New England Journal of Medicine* that provided some evidence supporting our explanation. In it, we documented the presence of two conditions that supported our theory.

The first was that we demonstrated that the key precondition for our hypothesis existed. Blacks and whites were indeed not treated by the same doctors. By looking at Medicare patients we were able to show that the care of black patients was heavily clustered among a small group of doctors - it took only 20 percent of these doctors to account for 80 percent of the care blacks received. Whites were different. Their care was mostly with other doctors.

Then we compared the doctors at the level of the individual patient visits, to ask the question "If I'm a typical Medicare patient who is black, what are the features of my doctor?" Then we asked that question again, for a typical white patient.

We found that the doctors were different. A black patient was less likely to have a doctor who was board certified than a white patient. We thought that was important because having board certification is one predictor of delivering high quality care. We also found that the primary care doctors who treated blacks had fewer resources to direct at the care of their patients. They had a harder time making referrals, or electively admitting patients to the hospital, or getting imaging tests.

Most interesting, although we didn't realize the importance fully at the time, the financing of the practices was different. It's not surprising in retrospect, but blacks went more often to doctors who provided free care or care reimbursed through low-paying Medicaid. This meant that the doctors who treated blacks were just less well financed, and so probably less well staffed with ancillary support services, and more hurried.

Although we could not link these doctor differences to care disparities, our findings provided support to the idea that care setting matters and adversely affects blacks. Around the time of this paper, and over the years since, this finding has been reproduced numerous times. Be it doctors or hospitals or surgeons or dialysis centers or managed care insurance companies, lower quality overall seems to be associated with having more black patients and fewer whites.

Recently colleagues of mine looked at some more detailed aspects of practices that treat large numbers of minority patients, and estimated that the impact of low payment rates from Medicaid were a sizable contributor to access problems, and led to shorter patient visits too.

My colleagues and I have also recently finished an analysis that is not yet published, so I can only present the general findings. We are finding that for Medicare patients who are black and white, the important predictors of getting lower quality care are your socio-economic status, and how good the quality of care is that your doctor gives his or her other patients. We were unable to detect any consistent evidence that doctors are treating their black and white patients differently per se.

My colleagues and I are in general agreement that these findings are consistent with the plausible hypothesis that first and foremost care for blacks is of lower quality because blacks are accessing a part of the system that is poorly functioning. Little if any of the under-treatment appears to be due to doctors singling out minorities for lower quality care.

None of us take the challenges posed by this alternative explanation for health disparities lightly. In ways, it will be harder to ameliorate this problem. But the payoff will be more durable and robust.

So, you have asked me here today to talk about health disparities and what our research suggests about their origins. That research rests in a social context in which many people arrived early at a conclusion that discrimination (conscious or unconscious) lay at the heart of treatment disparities.

Our work has provided a different explanation. One in which we have a poorly distributed health care system, in which the lowest quality resources are in the neighborhoods with the most needy individuals. If correct, the mechanism suggests that an approach that targets these high risk areas will be the best way to improve care and outcomes for patients.

Thank you again for inviting me. I look forward to your questions.

Statements: Second Panel

William R. Lewis

On behalf of the American Heart Association, its American Stroke Association division, and our more than 22 million volunteers and supporters, I want to express our appreciation for the opportunity to address the U.S. Commission on Civil Rights and to share information regarding our efforts to reduce health disparities involving cardiovascular disease and stroke. Addressing health disparities and improving health care quality are high priorities for the American Heart Association. Importantly, eliminating health care disparities represents one of the tenets of our recent Association statement of principles for health care reform. My name is Bill Lewis, and I am a cardiologist practicing at MetroHealth Medical Center. MetroHealth Medical Center serves as the county hospital in Cleveland, Ohio and is affiliated with Case Western Reserve University. I am an associate professor of medicine at Case Western Reserve and serve as the chief of clinical cardiology for MetroHealth Medical Center. I am a volunteer for the American Heart Association and I am actively involved with the AHA's Get With the Guidelines Quality Improvement Program. The presence of disparities in health care has been recognized for decades. The challenge is to identify and implement effective strategies for translating our scientific knowledge into daily practice for all Americans without regard to race, ethnicity, gender or socioeconomic status. We know scientifically how to reduce the risk and incidence of cardiovascular disease and stroke and improve outcomes for individuals with cardiovascular disease and stroke. However, as a nation, we continue to struggle with how best to implement this knowledge into daily practice at large.

In our time together today, I will provide an overview of the American Heart Association's approach to bridging the gaps in health and health care disparities involving cardiovascular disease and stroke. In addition, I will highlight and provide additional details regarding an innovative program that the American Heart Association developed to tackle these difficult challenges.

There is good news. Although we face significant challenges in addressing health disparities in the United States and additional research is needed, we have identified some concrete strategies for improving the quality of care for all Americans.

Overview on Disparities for Individuals with Cardiovascular Disease and Stroke

There is no question that significant and unacceptable levels of health disparities have existed for many years across the spectrum of medical conditions, including cardiovascular disease and stroke. The groundbreaking 1985 report of the U.S. Secretary of Health and Human Services' Task Force on Black and Minority Health found that there were nearly 60,000 more deaths in minority populations than would have been expected between 1979 and 1981 based on the rate in the non-minority population. About one-third of these excess deaths were due to heart disease and stroke.⁵²

⁵² U.S. Department of Health and Human Services. 1985 Report of the Secretary's Task force on Black and Minority Health. Washington, DC: US Department of Health and Human Services; 1985.

These disparities continue to persist. For example, in 2000, the U.S. Department of Health and Human Services reported that heart disease death rates were more than 40 percent higher for African-Americans than for whites.⁵³ Racial and ethnic minority populations confront more barriers to cardiovascular disease diagnosis and care, receive lower quality treatment and experience more communication barriers.⁵⁴ Numerous studies have demonstrated disparities in heart disease and stroke risk factor management on the basis of race, ethnicity and gender, including blood pressure control, cholesterol management and the treatment of diabetes and obesity.⁵⁵

In short, racial and ethnic minority populations are at greater risk of cardiovascular disease and stroke, may receive more sub-optimal care, and subsequently experience worse outcomes, including death. As a group, these individuals have less access to health care services than the rest of the population, and the health care received is lower in quality. At the same time, there are fewer minority physicians in the health care workforce. Among cardiologists in 2001, only 2 percent were black, 3.8 percent were Hispanic, and 12.7 percent were Asian. There is also limited awareness among cardiovascular practitioners about health disparities. For example, only 35 percent of cardiologists recently surveyed agreed that disparities in overall care exist in the United States, and only 5 percent believed that disparities exist among the patients receiving care from them.⁵⁶

Bridging Health Disparities is a Priority for the American Heart Association

In 2003, the American Heart Association convened a three-day summit to examine health disparities related to cardiovascular disease and to assist in developing the next phase of the American Heart Association's scientific, programmatic and advocacy efforts to address these important issues.

The participants in the summit identified a number of important recommendations that are guiding the American Heart Association in its ongoing efforts. These recommendations include, but certainly are not limited to, the following:

- Stratify and report data by racial/ethnic groups, and when possible, report data in the primary language that patients speak;
- Improve minority access to quality care;
- Increase screening and prevention of cardiovascular disease;
- Increase the number of racial/ethnic minorities who work in health care and improve cultural competency among health care providers;

⁵³ U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. Washington, DC: US Government Printing Office; 2000.

⁵⁴ Yancy CW, Benjamin EJ, Fabunmi RP, Bonow RO. Discovering the Full Spectrum of Cardiovascular Disease: Minority Health Summit 2003. Executive Summary. *Circulation*. 2005;111:1339-1349. [hereinafter Yancy et al. 2005]

⁵⁵ Lloyd-Jones D, Adams R, Carnethon M, De Simone G, et al. Heart disease and stroke statistics—2009 update: a report from the American Heart Association Statistics Committee and Stroke Statistics Subcommittee. *Circulation*. 2009; 119: 480–486, e21–e181.

⁵⁶ Lurie, N, Fremont A, Jain AK, Taylor SL, McLaughlin R, Peterson E, Kong W, Ferguson TB. Racial and Ethnic Disparities in Care: The Perspectives of Cardiologists. *Circulation*. 2005;111:1264-1269.

- Increase research on the genetic and environmental factors that contribute to racial/ethnic health disparities and increase the participation of minorities in research and as investigators; and
- Provide patients and the public with culturally and linguistically appropriate health care and educational materials.⁵⁷

In its federal advocacy efforts, the American Heart Association has recognized that the collection of data about health disparities is a pivotal first step in better identifying and eliminating disparities in care and has therefore prioritized the better collection of data related to race, ethnicity, gender, and where appropriate, primary language. For instance, the Association worked to secure a provision in the Medicare Improvements for Patients and Providers Act of 2008 that helps identify and eliminate disparities in the quality of health services for minorities and women enrolled in the Medicare program. The Association also supported adding health disparities language to the health information technology provisions of the economic stimulus law passed by Congress in February, 2009.

The American Heart Association has also continued to pursue and refine a number of programmatic interventions to address health disparities, such as its Power To End Stroke movement to raise awareness among African-Americans about their increased risk of stroke. In particular, however, I would like to highlight the promising developments involving the American Heart Association's Get With The Guidelines program.

The American Heart Association's Get With The Guidelines Program: A Model for Improving Quality and Addressing Health Disparities

In 2000, the American Heart Association launched a program called Get With The Guidelines that currently focuses on quality improvement for three conditions: coronary artery disease, heart failure and stroke. The program provides multiple interventions to help improve the care provided to patients by helping providers adhere to the evidence-based guidelines for treating these common conditions and preventing subsequent acute events. Providers obviously remain free to customize the care provided to each patient, but the evidence-based recommendations for these diseases reflect non-controversial aspects of care that are supported by a wealth of scientific evidence.

The Get With The Guidelines program focuses on acute hospitalizations as an opportunity to ensure that important clinical strategies for avoiding subsequent acute events (so-called "secondary prevention") are implemented immediately, educational efforts are initiated to help patients manage their disease and steps are taken to coordinate the transition of each patient's care to the community setting. These are critical building blocks to improving patient outcomes and ensuring that all patients receive the full scope of care recommended by the evidence-based clinical guidelines.

The components of the Get With The Guidelines program include the following:

- A web-based patient management tool that permits the real-time input of data regarding each patient;

⁵⁷ Yancy et al. 2005.

- A clinical decision support function, which prompts providers to ensure that they consider all of the recommended aspects of care for each patient. In a health system in which multiple providers care for patients in a variety of settings, this tool helps the hospital team ensure that all of the fundamental aspects of care, including the transition to the community setting, are addressed for each patient.
- A real-time benchmarking function, in which individual physicians and hospitals can compare their performance on a variety of quality of care measures against a large database providing statistical averages for a variety of provider types and regions. The ability to evaluate this information on a timely basis may help individual providers identify opportunities for improving patient care and identifying ways to do so on an ongoing basis.
- Educational materials are provided for use by physicians, nurses, patients, family members and other caregivers. The American Heart Association provides targeted educational materials for individuals from a variety of cultural backgrounds written in a variety of languages.
- Tools are offered to help hospital providers communicate with community-based providers regarding each patient's care and any recommendations for follow-up.
- The program also functions as a robust clinical registry that permits further scientific evaluation of the effectiveness of specific interventions and the progress made in improving care, including the analysis of the rate of uptake of new scientific knowledge at the community level, the quality of care provided, and the clinical outcomes for individuals belonging to the various race, ethnicity and gender based subgroups.
- Recognition for high quality care is also provided to hospitals that consistently follow treatment guidelines. This may enhance a hospital's status within the community, and hospitals may use this data in negotiations with insurance companies as evidence of high quality care.

Taken in combination, these elements form a program that has been shown – through extensive scientific study – to improve adherence to evidence-based guidelines and to reduce disparities among various subgroups of patients. To date, more than 1.7 million patients have been enrolled in Get With The Guidelines. This has given clinicians and researchers a great opportunity to address quality cardiovascular and stroke care for all patients, including those in special populations.

In particular, I will highlight four observations from the clinical data on Get With The Guidelines, followed by an overview of some of the latest literature affirming these observations.

1. Get With The Guidelines has demonstrated substantial narrowing or elimination in racial and ethnic disparities for health services provided within hospitals and upon hospital discharge for patients with coronary artery disease, heart failure and stroke. In fact, the clinical outcomes for minority patients in hospitals participating in Get With The Guidelines are equal when compared to their white counterparts.
2. Get with the Guidelines has enhanced the transparency of issues involving disparities in health on the basis of race, ethnicity and gender. At the micro-level, these data help individual physicians and hospitals address disparities in care on a case-by-case basis. At

a macro-level, the Get With The Guidelines clinical registry is now providing a rich source of data that highlights the ongoing need to address disparities in care. These data on health disparities among patients with coronary artery disease, heart failure and stroke are reported in the American Heart Association's 2009 Statistical Update and will be published in future articles and updates. Such data represent a critical step forward in defining and eradicating health disparities.

3. Get with the Guidelines has permitted the study of health disparities involving interventions and technologies that go beyond the core performance measures. For example, this registry has been used to study and identify significant disparities in the use of cardiac resynchronization therapy and implantable cardioverter-defibrillators, devices that have been shown to improve survival in patients with heart failure. Women and minorities are approximately 50 percent less likely to receive an implantable defibrillator as treatment for heart failure despite having the same indications for therapy. The availability of these data now allow for further investigation into explanations for these differences and strategies that may close these treatment gaps.
4. Participation in the Get With The Guidelines program has been embraced by many hospitals throughout the United States. These hospitals value the significant benefits of participating in this quality improvement program. Currently, there are 1,525 hospitals using Get With The Guidelines programs. The largest number of hospitals, 1,304, participates in the stroke program. Approximately 1,000 hospitals participate in the coronary artery disease and heart failure programs. This is about a third of all hospitals in the United States. Participating hospitals represent a diverse group comprising large and small, academic and non-academic, and urban and rural hospitals located in every state.

To help illustrate the ways in which Get With The Guidelines is being used to address health disparities, I will provide you with a brief survey of the most recent literature involving Get With The Guidelines in the context of heart failure, stroke, and coronary artery disease. I am pleased to report that all of this information has been or will soon be published in the peer-reviewed literature, and additional studies are currently underway that will help further guide our efforts to address health disparities.

Before describing some of this literature in more detail, it is important to note that, although this briefing is focused on racial and ethnic disparities, large disparities also exist among women, compared to men. Therefore, I will also share some data related to gender-based differences and disparities.

Get With The Guidelines—Heart Failure

Heart failure (HF) is the leading cause of hospitalization and re-hospitalization for the Medicare population. Black and possibly Hispanic populations are at an increased risk for developing HF, do so at an earlier age, experience greater disability, and possibly higher risk of death at younger ages.

In a report from the OPTIMIZE-HF registry, a precursor to Get With The Guidelines-HF, inpatient outcomes and adherence to inpatient quality measures are at least similar and in-

patient mortality is in fact better for black than white patients.⁵⁸ Preliminary analysis of data from the Get With The Guidelines-HF database confirms this finding among more than 78,000 patients in about 250 hospitals participating in the program.⁵⁹ This study, whose final findings will be published soon, demonstrates that among participating hospitals in the Get With The Guidelines-HF program, equitable quality care is attainable across major racial and ethnic groups. There was also consistent improvement in the delivery of equitable quality care among all heart failure patients in the Get With The Guidelines-HF program. These findings support the notion that quality improvement initiatives may be an important instrument in reducing or eliminating racial/ethnic differences in the delivery of cardiovascular care.

Another study reviewed the frequency and characterizations of heart failure patients treated with cardiac resynchronization therapy (CRT), an emerging therapy supported by the clinical guidelines, by various factors, including race. In this study of 33,898 patients admitted to 228 hospitals between 2005 and 2007 using the Get With The Guidelines-HF program, the use of CRT was analyzed.⁶⁰ One of the major findings of this study was that cardiac resynchronization therapy (a form of pacemaker therapy) use varies by age, race, hospital site and geographic region. CRT use was less common in black patients compared with white patients. This disparity is particularly concerning because black patients have a higher incidence of nonischemic cardiomyopathy, which has been shown to be associated with greater rates of clinical response to CRT. Also, black patients are more likely to develop advanced symptomatic heart failure and to have a higher rate of re-hospitalization.⁶¹ This study highlights an example of Get With The Guidelines helping researchers to identify where significant racial disparities exist in the use of treatments that go beyond the core performance measures. Further research is needed to understand the reasons for the variations in CRT use at the patient, physician and hospital levels and to implement programs to improve the awareness and promotion of evidence-based use of medical devices in heart failure.

Get With The Guidelines—Stroke

Stroke is the third-leading cause of death and a leading cause of morbidity and long-term functional disability. An estimated 700,000 strokes occur each year in the United States, and 200,000 of these events are recurrent strokes. Blacks have almost twice the risk of first-ever stroke compared with whites. Despite widely available evidence supporting clinical interventions that improve health outcomes for patients hospitalized due to stroke, many patients do not receive recommended interventions.

⁵⁸ Yancy CW, Abraham W, Albert N, et al. Quality of Care and Outcomes for African Americans Hospitalized with Heart Failure: Findings from the OPTIMIZE-HF (Organized Program to Initiate Lifesaving Treatment in Hospitalized Patients with Heart Failure) Registry. *J. Am. Coll. Cardiol.* 2008;51:1675-1684.

⁵⁹ Yancy CW, Fonarow GC, LaBresh KA, Albert NM, Ellrodt G, Hernandez AF, Yu Y, Peterson ED. Disparate quality of care for black and Hispanic heart failure patients: a report from Get With The Guidelines – Heart Failure. *J Card Fail.* 2007;13:S157.

⁶⁰ Piccini JP, Hernandez AF, Dai D, Thomas KL, Lewis WR, Yancy CW, Peterson ED, Fonarow GC. Use of Cardiac Resynchronization Therapy in Patients Hospitalized with Heart Failure. *Circulation.* 2008;118:926-933.

⁶¹ Thomas KL, East MA, Velaquez EJ, Tuttle RH, Shaw LK, O'Connor CM, Peterson ED. Outcomes by Race and Etiology of Patients with Left Ventricular Systolic Dysfunction. *Am J Cardiol.* 2005;96:956-963.

In preliminary analysis of nearly 400,000 ischemic stroke patients at approximately 1,100 hospitals participating in Get With The Guidelines-Stroke, researchers have found that, after adjusting for risk, black patients received lower rates of guideline-based care, while Hispanic patients received care similar to whites for all measures. However, the quality of care improved over time for all three racial/ethnic groups.⁶²

In another, recently published study, data from 790 hospitals participating in the Get With The Guidelines-Stroke program demonstrated that participation in the program resulted in sustained and substantial improvements on seven measures of stroke care regardless of size, geography and teaching status of the hospitals.⁶³ Performance improvement varied across measures, with intravenous tPA use, lipid lowering, and smoking cessation showing the highest absolute percent change. Antithrombotic use and anticoagulation for atrial fibrillation showed smaller absolute improvements. An increase in the intravenous tPA treatment rate of 30 percent across the participating sites translates into a substantial expected decrease in functional disability in the population served.

This study has important implications for public policy. The data show that focused quality improvement efforts, coupled with data reporting in a structured learning environment, can produce dramatic results. Such a program can be used to bring equity across different subpopulations that address disparities in care.

As a result of such data, the proposed adoption of stroke measures by the Centers for Medicare & Medicaid Services (CMS) into the Medicare hospital quality reporting program has the potential to greatly expand the efforts to improve stroke care. The American Heart Association is strongly urging CMS to implement the stroke measures as quickly as possible.

Researchers also have examined the quality of care that women receive after strokes using data from the Get With The Guidelines-Stroke program.⁶⁴ Although sex differences on individual performance measures were relatively modest, women consistently are less likely to receive evidence-based care for stroke compared to men. Further study is necessary to identify the causes and consequences of these sex-based differences in care.

Get With The Guidelines—Coronary Artery Disease (CAD)

Studies have also examined whether participation in the Get With The Guidelines program results in greater adherence to guidelines for coronary artery disease.⁶⁵ In general, adherence to published guidelines is known to be variable even among top hospitals.⁶⁶

⁶² Lloyd-Jones D, Adams R, Carnethon M, De Simone G, et al. Heart disease and stroke statistics—2009 update: a report from the American Heart Association Statistics Committee and Stroke Statistics Subcommittee. *Circulation*. 2009; 119: 480–486, e21–e181.

⁶³ Schwamm LH, Fonarow GC, Reeves MJ, Pan W, Frankel MR, Smith EE, Ellrodt G, Cannon CP, Liang L, Peterson E, LaBresh KA. Get With the Guidelines Stroke is Associated with Sustained Improvement in Care for Patients Hospitalized with Acute Stroke or Transient Ischemic Attack. *Circulation*. 2009;119:107-115.

⁶⁴ Reeves MJ, Fonarow GC, Zhao X, Smith EE, Schwamm LH. Quality of Care in Women with Ischemic Stroke in the GWTG Program. *Stroke*. 2009;40:1127-1133.

⁶⁵ Lewis WR, Peterson ED, Cannon CP, Super DM, LaBresh KA, Quealy K, Liang L, Fonarow GC. Results with the Get With the Guidelines Quality Improvement Program. *Arch Inter Med*. 2008;168(16):1813-1819.

⁶⁶ McGlynn EA, Asch SM, Adams J, Keesey J, Hicks J, DeCristofaro A, Kerr EA. The Quality of Health Care Delivered to Adults in the United States. *N Engl J Med*. 2003;348(26):2635-2645.

Hospitals participating in the Get With The Guidelines-CAD program were compared with other hospitals for a fixed period of time, using the publicly available CMS Hospital Compare database. This study found that participation in the Get With The Guidelines-CAD program was associated with improved guideline adherence. This is one of the first studies to demonstrate that a quality improvement program is independently associated with increased adherence using an external, concurrent national database.

Although the improvements in adherence observed in this study were all in absolute terms, with more than 1 million patients hospitalized with acute myocardial infarction each year, these differences in performance would translate to tens of thousands more patients treated with recommended therapies each year if all hospitals provided the same level of performance as those participating in the Get With The Guidelines-CAD program.

In another example of the use of Get With The Guidelines to examine disparities in cardiovascular care, investigators addressed sex differences in medical care after acute myocardial infarction.⁶⁷ In this study, 78,254 patients with acute myocardial infarction in 420 hospitals between 2001 and 2006 were examined. Compared with men, women were less likely to receive early aspirin treatment, early treatment with beta-blockers, reperfusion therapy or timely reperfusion and a door-to-balloon time equal to or less than 90 minutes. Women also experienced lower use of cardiac catheterization and revascularization procedures after acute myocardial infarction. There may be multiple reasons for the observed differences in the use of these therapies, such as differences in baseline risk, multiple comorbidities or other modifiable factors and contributing etiologies. These factors are worth examining in future analyses of race and sex disparities and adherence to guideline recommended treatments.

Get With The Guidelines-Office of Minority Health Pilot Project

Through collaboration with the U.S. Department of Health and Human Services Office of Minority Health, Get With The Guidelines launched a quality improvement initiative targeting health care disparities with the goal being to use a quality approach to narrow treatment differences. The University of Mississippi was recruited as a test site. Data were collected serially over time to assess the core measures of quality for coronary artery disease and heart failure, and additional other measures of heart failure quality were involved.

That pilot study has demonstrated that at baseline, blacks and whites receive similar care when assessing the most well-established markers of quality. When examining emerging markers of heart failure quality, we demonstrated that for a novel therapy that is uniquely appropriate for blacks with heart failure, there was a nearly three-fold increase in the appropriate use of this therapy over time. Regarding the use of an implantable defibrillator, we noted that use increased from 35 percent to nearly 50 percent of those with an indication for the device—a rate similar to its use in all patients. It is our finding that a quality-driven approach represents at least one potential strategy that may narrow treatment gaps between groups and help to reduce health care disparities. Much work remains.

⁶⁷ Jneid H, Fonarow GC, Cannon CP, Hernandez AF, Palacios IF, Maree AO, Wells Q, Bozkurt B, LaBresh KA, Liang L, Hong Y, Newby LK, Fletcher G, Peterson E, Wexler L. Sex Differences in Medical Care and Early Death After Acute Myocardial Infarction. *Circulation*. 2008;118:2803-2810.

Summary Remarks

At the American Heart Association, we believe strongly that each person in the United States should always receive high quality care regardless of race, ethnicity, gender or other factors and that the promotion of evidence-based clinical practice guidelines will help to ensure that patients receive the appropriate care. The use of continuous quality improvement tools that include clinical decision support, such as Get With The Guidelines, help to translate practice guidelines into consistent use at the patient bedside and minimize clinician bias that can lead to disparities. As has been demonstrated by research, the Get With The Guidelines program is a powerful tool to improve patient care at the bedside. Using the registry function of this program, we are also able to bring greater transparency to the issues of health disparities in cardiovascular disease and stroke with meaningful scientific evidence from high impact publications using Get With The Guidelines registry data. As we extend our focus on quality, the opportunity exists to use quality as a gender-blind, race and ethnicity blind, and age-blind strategy to reduce treatment gaps between groups of patients and to optimize outcomes for patients with cardiovascular disease and stroke.

Thank you, and I would be pleased to answer any questions you may have.

Herman A. Taylor

Thank you, Commissioner.

Since the larger terrain of the topic “health disparities” has been well covered by several speakers on the panel, I will restrict my brief remarks to specific results of my group’s research, principally from The Jackson Heart Study (JHS), and reasonable implications of that research.

The JHS is the largest longitudinal study of African-American cardiovascular health ever undertaken. Our study is unique in that it will ultimately allow us to analyze the impact of a wide variety of factors -- psychological, social, nutritional, metabolic, and genetic – on cardiovascular disease (CVD). The cohort of African-American adults who comprise the JHS is notable for its diversity in socioeconomic status; such diversity offers the opportunity to look at the possible health consequences of differences in social position within the African-American community, a community which is all too often looked on monolithically without attention to the vast heterogeneity of the African-American experience. We will also be able to compare our data with suitably designed studies in other ethnic groups.

The JHS is a work in progress; so much of what I will say today will describe early results. (Note: JHS does NOT treat its participants; it is an observational study.) My main points will be the following:

1. Early results from the JHS dramatically confirm the high risk for CVD among the African-American community;
2. In the specific instance of hypertension, a leading CVD risk factor, increased levels of awareness, treatment and control of hypertension have been achieved within the Jackson African-American community;
3. The improvement in treatment outcomes and control of hypertension is encouraging; however, because of the much higher occurrence of hypertension (and other CVD risk factors) in blacks compared to other groups in the U.S., disparities in hypertension-related morbidity and mortality will persist;
4. Efforts to prevent hypertension (and other CVD risk factors) are a critical part of a strategy to eliminate disparities in cardiovascular disease and death.

Ominous levels of Risk

Obesity

We compared the rates of obesity in the Framingham Heart Study—a long-running renowned study of CVD in a white American population---with rates in the JHS (African-American) cohort. The overall prevalence of obesity in JHS and FHS was 53.3 percent and 27.1 percent respectively. JHS participants were more likely to be obese whereas FHS participants were more likely to be normal weight or overweight. The prevalence of stage 2 obesity (i.e., “very obese” status; BMI>35) was almost three times higher in JHS 35-54-year-olds compared to FHS (26.5 percent vs. 9.1 percent), whereas the adjusted prevalence of normal weight was 2.5 times higher in FHS (36.7 percent vs. 13.9 percent). The pattern of much higher levels of obesity among blacks was also seen in the older comparison groups.

Hypertension increased with increasing BMI in both Jackson and Framingham and was higher in the JHS at each BMI group. Among normal weight participants the proportion with hypertension was more than 3.5 times greater in Jackson (31.2 percent) compared to Framingham (8.6 percent). Notably, among normal weight participants, the proportion with diabetes was 6 times higher in Jackson (blacks) compared to Framingham (whites).

Metabolic Syndrome

Metabolic syndrome has become a subject of great interest. It is associated with three major disease epidemics in the U.S.: obesity, type 2 diabetes, and continued high rates of CVD. Metabolic syndrome is diagnosed when three or more metabolic disorders, including abdominal obesity, elevated plasma triglyceride concentration, low plasma HDL cholesterol concentration, elevated blood pressure, and elevated fasting glucose, are present.

Our analyses of data from JHS demonstrate extraordinarily high metabolic syndrome prevalence. Among those aged 35–84 the prevalence was 44.8 percent in women and 33.4 percent in men, far above corresponding national rates (e.g., latest NHANES rate <25%). Metabolic syndrome prevalence in the JHS is among the highest reported for population-based cohorts worldwide and is significantly associated with increased risk for heart disease and stroke. Both in men and women, the prevalence significantly decreases with higher household income and educational attainment.

Hypertension

Hypertension is likely the single most important treatable and controllable risk factor for CVD, however, controlling hypertension is a problem for many Americans, particularly blacks. There are national reports of widening disparities in the success rate of hypertension treatment between blacks and whites.

Encouraging Control Rates Possible

The data from the JHS stand in contrast to the national data. Percent of participants with controlled hypertension in the Jackson Heart Study (All African-American):

~70% Blacks (the same as white control rates nationally)

To summarize: national data show a persistent disparity in hypertension control rates for African-Americans despite levels of awareness and treatment that are similar or higher than those for whites. However, the JHS may carry a hopeful message: that under some circumstances, such as those represented by the JHS cohort, equal rates of hypertension control are possible for blacks and whites.

What is different about the Jackson Heart Study participants? Is something different in Jackson, MS?

Although the comparisons above were not adjusted for risk factors or study design differences, our findings are consistent with the other research, where better treatment and control were suggested in the “stroke belt” compared with other parts of the country. This indicates that higher rates of control are achievable than customarily assumed.

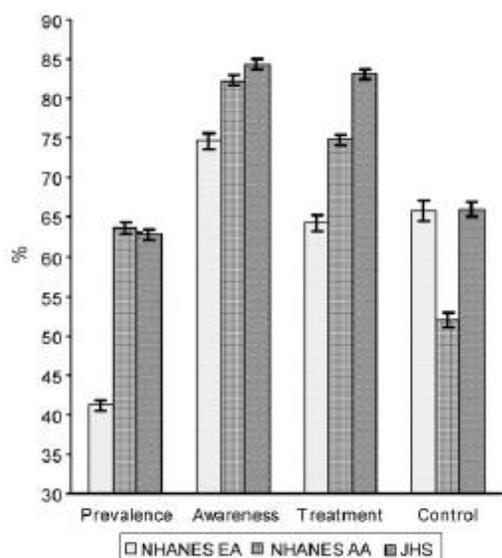


Figure 2. Hypertension status in JHS and NHANES. Error bars represent binomial SE.

Possible contributors to favorable control rates in the JHS:

- high levels of physician motivation;
- education surrounding hypertension;
- positive effects of being in a study on heart disease (JHS is observational only);
- the regular flow of public messages about the study and heart health delivered to the black community

Discouraging Disparities Despite High Treatment Rates

But is attaining equally good hypertension control rates between blacks and whites enough to eliminate the disparity in hypertension-related disease and death?

Despite favorable rates of control in Jackson, high levels of CVD morbidity and mortality persist. Wide ethnic differences in stroke, heart failure and moderate differences in heart attack rates – all contributed to by hypertension -- are still seen in the Jackson area, according to surveillance data from a sister study of the JHS, *Atherosclerosis Risk in Communities* (ARIC). (Data to be quoted during briefing.)

Disparities in cardiovascular health cannot be eliminated without preventing the emergence of differences in the rates of the risk factors for CVD. Treating disease is obviously important and can be life saving, but most often it does not completely return people to normal health. The situation is akin to a car damaged in an accident: many things can be restored or replaced, but the vehicle cannot be returned to original condition. When disease becomes established, the trajectory of health is altered, and the health outcomes between a person who is treated for a disease and one who has never had the disease are disparate. We must increase our understanding of why there are disparate rates of risk factor onset, and act upon that knowledge. While we continue to search for answers to physiological risk factors related

to excess CVD, at minimum we must address the identified societal factors that contribute to the problem. Most important to this effort is prevention.

Much of the expertise in these areas of prevention lies in the fields of nutrition, behavior, psychology and social epidemiology, and I refer you to experts whom I will mention during my presentation. However, some general areas of focus are clear:

- Food supply characteristics (caloric intake; salt intake; fast foods; other eating outside the home)
- Physical activity levels (school, workplace, neighborhood, built environment)
- The burden of persistent discrimination (interpersonal, institutional, environmental)

Conclusion

The bottom line -- to reduce disparities in hypertension and CVD, we must decrease the number of African-Americans that ever become hypertensive. Our research and that of others strongly suggest that a multi-pronged approach is imperative:

1. equalization of awareness, access, and appropriate utilization of care;
2. investment in research to further define the basis of higher risk factor levels among ethnic minorities; and
3. use of evidence-based prevention efforts that go beyond health care institutions into the societal milieu are critical to resolving America's ethnic health disparities.

Health equity cannot be achieved without balanced attention to risk prevention and treatment.

U.S. Commission on Civil Rights

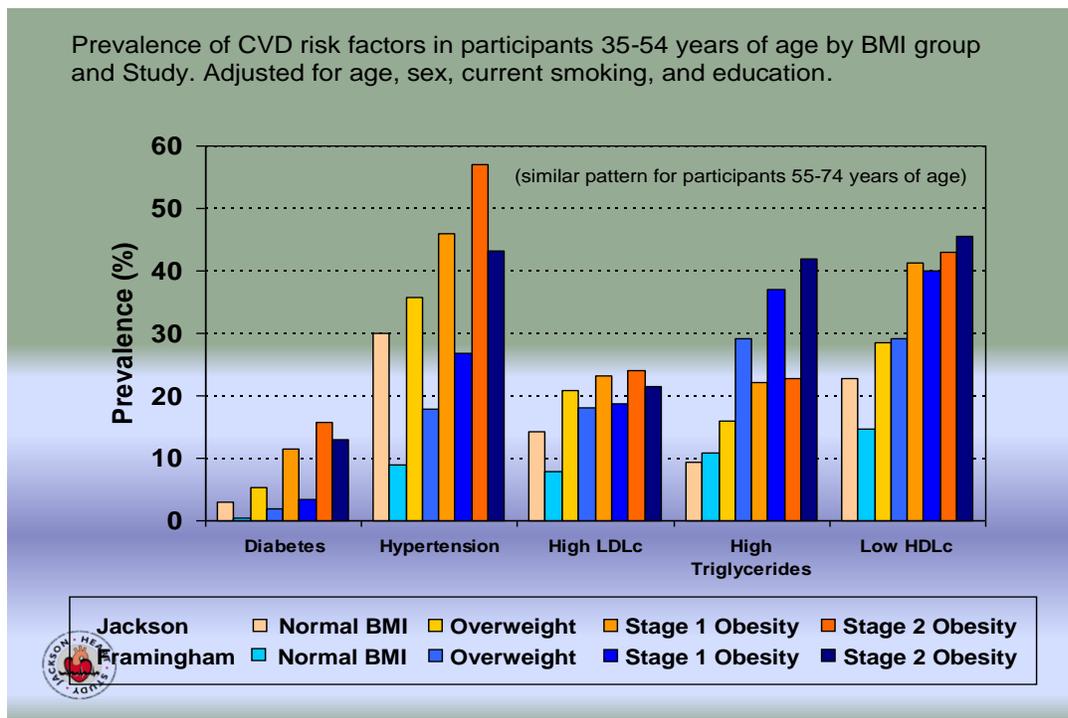
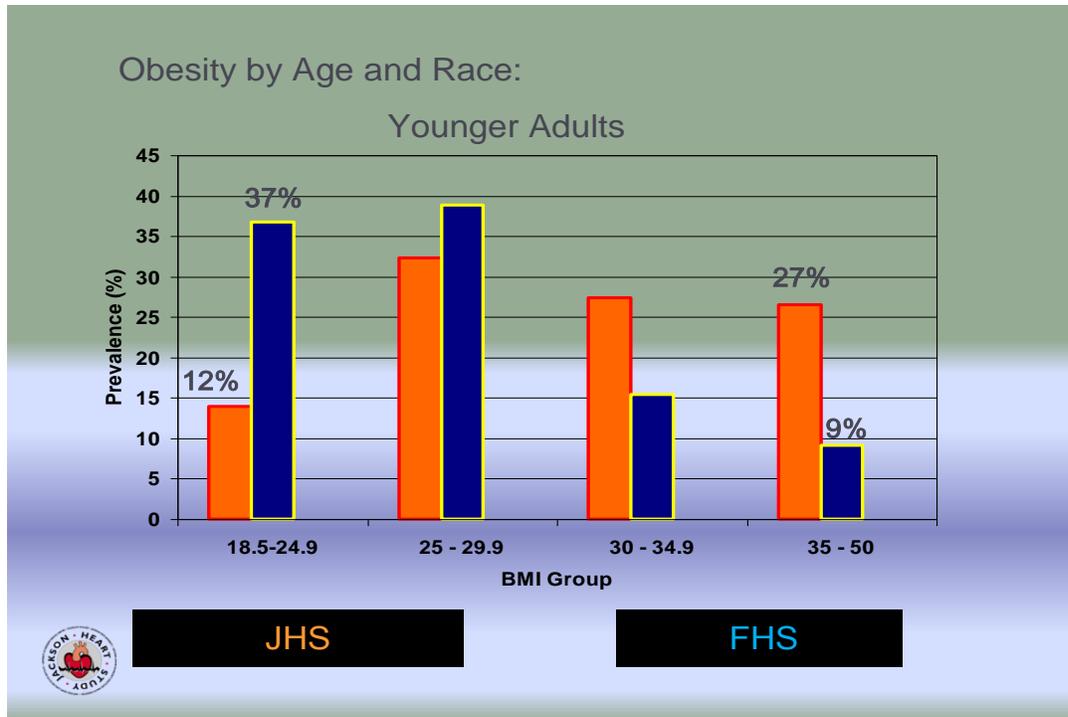
Briefing on Health Disparities

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Metabolic Syndrome Patterns in the JHS

Cardiovascular and Metabolic Risk

ORIGINAL ARTICLE

Distinct Component Profiles and High Risk Among African Americans With Metabolic Syndrome

The Jackson Heart Study

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OBJECTIVE— Health of African Americans with diabetes and cardiovascular disease (CVD). The African-American population has not been investigated for prevalence of metabolic syndrome and assessed its contribution to CVD in the Jackson Heart Study (JHS) cohort.

RESEARCH DESIGN AND METHODS— who were recruited at baseline during 2000–2004. Odds ratios (ORs) were estimated in a logistic regression model for CVD, CHD, and CVD were estimated in those with and without metabolic syndrome.

RESULTS— Among those aged 35–84 years, women and 32.7% in men. Elevated blood pressure, low HDL cholesterol (37.2%) were highly prevalent. Prevalence rates for CVD, CHD, and CVD were estimated for age and sex, metabolic syndrome was a significant risk factor for CVD (OR 1.7 [95% CI 1.4–2.1]), CI compared with those without CVD, CHD, or CVD.

CONCLUSION— Metabolic syndrome prevalence for population-based cohorts worldwide and is CVD, CHD, and CVD. Abdominal obesity, increased triglyceride elevation are surprisingly emerging as a leading contributor to metabolic syndrome in the African-American cohort.

Table 1—Prevalence of metabolic syndrome and individual metabolic factors by age and sex in the JHS cohort, 2000–2004

	Subjects (n)	Metabolic syndrome	Elevated blood pressure	Abdominal obesity	Low HDL cholesterol	Elevated glucose	Elevated triglyceride
Age (P _{adj})		<0.0001	<0.0001	<0.0001	NS	<0.0001	<0.0001
Overall	4,706	39.4	70.4	64.6	37.2	29.7	16.6
21–34 years	236	16.5	24.6	51.7	44.9	6.8	9.8
35–44 years	911	25.4	48.7	58.7	40.3	13.9	11.3
45–54 years	1,169	36.4	66.3	64.8	38.9	22.4	16.2
55–64 years	1,277	48.2	81.7	67.3	35.4	40.8	19.7
65–74 years	845	50.2	89.1	70.4	33.3	43.2	19.4
75–84 years	244	45.5	88.5	64.3	34.1	38.5	18.4
85+ years	15	33.3	93.3	53.3	13.3	46.7	13.3
Sex (P _{adj})		<0.0001	NS	<0.0001	<0.0001	NS	<0.0001
Female	2998	43.3	70.7	76.5	39.5	29.6	14.5
Male	1708	32.7	69.9	43.7	33.1	29.9	20.1

Individual taking diabetic medication or fasting glucose level >126 mg/dl excluded from analysis. High blood pressure, abdominal obesity, low HDL cholesterol concentration, high glucose, and high triglyceride concentrations



Cardiovascular diseases (CVDs) and diabetes are the most common causes of death and disability in the U.S. and in most developed countries. In the U.S., African Americans have CVD significantly earlier and more often and experience poorer outcomes than their

equally in the well-documented national declines in CVD mortality of the past decades (3). Differences in prevalence rates of conventional risk factors as well as socioeconomic factors have been pro-

portional Health and Nutrition Examination Survey (NHANES) sample. For instance, African-American men had the highest age-adjusted prevalence of hypertension and African-American women had the highest prevalence of abdominal obesity.

HTN Control by Age and Sex



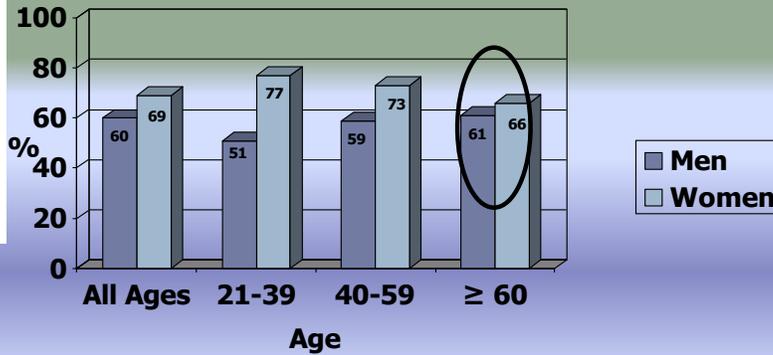
Prevalence, Awareness, Treatment, and Control of Hypertension in the Jackson Heart Study
 Sharon B. Wyatt, Emma L. Ayub-Dobson, James B. Whitford, Sara A. Condy, Evelyn E. Williams, Nicholas S. Anagnostis, Whitney J. Edwards, Harrison A. Taylor, and Sharon W. Jones
 Hypertension 2008;41:650-656. doi:10.1161/HYPERTENSION.2008.01.000000
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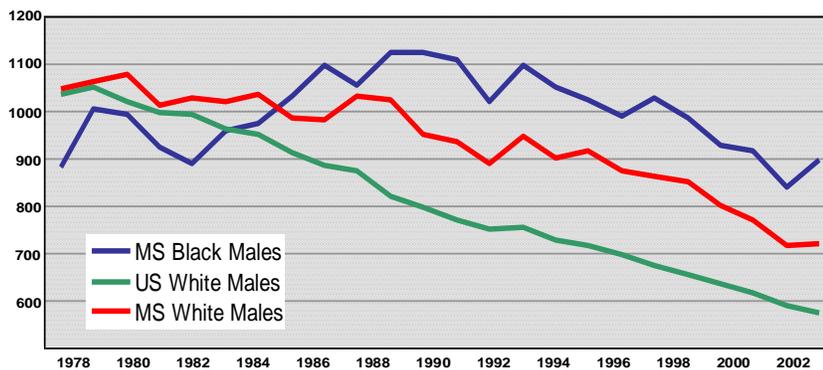
Overall HTN Control = 66.4%



n=1753

Wyatt, et al: *Hypertension* 2008

Racial Disparity Trends in Cardiovascular Mortality for MS Males



Age-Adjusted Cardiovascular Mortality Rates (Ages 35 Years and Over) utilizing Compressed Mortality File and CDC Wonder.



Jackson Heart Study

- A Major strength
 - “...the **simultaneous** examination of a comprehensive, theory-driven set of social, ethnoracial, psychological, and environmental variables alongside traditional and nontraditional biological measures” (Payne et al., 2005, p. S6-38).



Psychosocial/Sociocultural Measures

- CES-D
- Global Stress
- Weekly Stress Inventory
- Daily Hassles
- Religion
- Socio-economic Status
- Violence
- Anger (CHOST, Anger In & Out)
- Hostility
- Coping Racism & Discrimination
- Social Support
- Optimism
- John Henryism
- Job Strain

The logo for the Jackson Heart Study, featuring a circular emblem with a heart and the text 'JACKSON HEART STUDY' around the perimeter.

ORIGINAL REPORTS: RESEARCH DESIGN

DEVELOPMENT AND PSYCHOMETRIC TESTING OF A MULTIDIMENSIONAL INSTRUMENT OF PERCEIVED DISCRIMINATION AMONG AFRICAN AMERICANS IN THE JACKSON HEART STUDY

Objective: Assessing the discrimination-health disparities hypothesis requires psychometrically sound, multidimensional measures of discrimination. Among the available discrimination measures, few are multidimensional and none have adequate psychometric testing in a large, African American sample. We report the development and psychometric testing of the multidimensional Jackson Heart Study Discrimination Instrument (JHSDIS).

Methods: A multidimensional measure assessing the occurrence, frequency, attribution, and coping responses to perceived everyday and lifetime discrimination; lifetime burden of discrimination; and effect of skin color was developed and tested in the 5302-member cohort of the Jackson Heart Study. Internal consistency was calculated by using Cronbach α coefficient. Confirmatory factor analysis established the dimensions, and intercorrelation coefficients assessed the discriminant validity of the instrument.

Setting: Tri-county area of the Jackson, MS metropolitan statistical area.

Results: The JHSDIS was psychometrically sound (overall $\alpha = .78$; $\alpha = .84$ and $.77$, respectively, for the everyday and lifetime subscales). Confirmatory factor analysis yielded 11 factors, which confirmed the a priori dimensions represented.

Conclusions: The JHSDIS combined three scales into a single multidimensional instrument with good psychometric properties in a large sample of African Americans. This analysis lays the foundation for using this instrument in research that will examine the association between perceived discrimination and CVD among African Americans. (*Ethn Dis.* 2009;19:56-64)

Key Words: Discrimination, Racism, Jackson Heart Study, African American, Cardiovascular Disease

Mario Sims, PhD; Sharon B. Wyatt, PhD; Mary Lou Gutierrez, PhD; Herman A. Taylor, MD, MPH; David R. Williams, PhD, MPH

INTRODUCTION

Discrimination or unfair treatment contributes to physical and mental health disparities among racial and ethnic minorities.¹⁻³ Recent studies have provided additional evidence of the role of discrimination in cardiovascular disease,⁴ but measurement issues continue to plague the field. Several measures of discrimination have been developed^{2,5} and tested⁶⁻⁸ since the early 1990s, yet none have captured the multiple dimensions of the construct, and no gold standard measure of discrimination exists. Studies to date have been limited by small sample size and, until recently, little assessment of reliability and validity in specific populations was available.⁶ Wyatt et al.⁹ reported the need for a multidimensional discrimination scale that could "...tease out the complex additive and interactive relationships that are likely to account for the relationship of various dimensions of racism and cardiovascular disease in African Americans." The Jackson Heart Study (JHS), a single-site longitudinal, population-based, cohort study of 5302 persons initiated in the fall of 2000 to prospectively investigate the determinants of cardiovascular disease among African Americans in the Jackson, Mississippi,

This article details the development of a multidimensional discrimination instrument and reports on its psychometric properties among African Americans.

metropolitan statistical area, provided a unique opportunity to address this gap.¹⁰ This article details the development of a multidimensional discrimination instrument and reports on its psychometric properties among African Americans.

METHODS

Development of the JHSDIS

The JHS Discrimination Instrument (JHSDIS) was developed through a multistage process based on review of existing discrimination measures, findings from focus groups with JHS-eligible participants, and field testing of preliminary versions in a population comparable to the JHS sampling frame. This process identified two major categories of discrimination (everyday and major life events), with secondary measures of frequency, attribution, and coping response; lifetime burden; and effect of skin color (treatment by Whites and Blacks). We created the JHSDIS to assess daily discrimination, effect of skin

From the School of Medicine (MS, SBW, HAT), School of Nursing (SBW), the Examination Center, Jackson Heart Study (MS, SBW, HAT), University of Mississippi Medical Center; Walden University (MLG), Jackson, Mississippi; Harvard School of Public Health, Boston, Massachusetts (DRW).

Reprints will not be available from the authors. Address correspondence to: Mario Sims, PhD; Jackson Heart Study; 350 West Woodrow Wilson Dr, Ste 701; Jackson, MS 39213; 601-979-8771; 601-979-8701 (fax); msims2@medicine.umsmed.edu

Table 1. Dimensions of everyday, lifetime, and burden of discrimination among African Americans by age and sex in the Jackson Heart Study, 2000-2004

	Total, %	Age				X ² P value	Sex		X ² P value
		21-34 years (n=244), %	35-44 years (n=991), %	45-64 years (n=2688), %	>=65 years (n=1277), %		Female (n=3329), %	Male (n=1871), %	
a. Occurrence of Everyday Discrimination									
Treated with less courtesy	64.8	70.9	73.8	68.2	49.6	<.001	66.0	62.8	0.02
Treated with less respect	61.0	69.1	72.6	64.5	43.2	<.001	61.2	60.7	0.72
Poor service at restaurant	56.5	67.9	72.4	61.1	32.4	<.001	56.7	56.2	0.76
People think you are not smart	59.1	70.0	68.5	61.2	45.3	<.001	60.3	57.1	0.02
People are afraid of you	39.5	58.0	52.2	42.1	20.8	<.001	35.4	46.9	<.001
People think you are dishonest	33.6	46.9	45.8	34.8	19.2	<.001	29.8	40.4	<.001
People think you are not as good	59.6	68.7	69.2	62.3	44.4	<.001	58.8	60.9	0.13
Called names or insulted	34.7	44.9	44.4	35.8	22.6	<.001	33.0	37.6	0.001
Threatened or harassed	25.3	26.8	31.1	28.1	14.5	<.001	23.6	28.2	<.001
b. Occurrence of Lifetime (Major Life) Discrimination									
At School (n=2250)	43.3	37.0	49.2	45.9	34.6	<.001	43.1	43.8	0.65
Getting a job (n=2310)	44.5	30.5	51.6	48.7	32.7	<.001	41.6	49.6	<.001
At Work (n=3336)	64.3	61.3	69.5	67.5	54.1	<.001	64.1	64.6	0.28
Get Housing (n=673)	13.0	8.23	15.5	14.0	9.7	<.001	11.3	16.0	<.001
Getting Resources (n=1950)	37.6	24.4	42.0	42.0	27.5	<.001	33.9	44.3	<.001
Getting Medical Care (n=715)	13.8	4.9	13.1	14.6	14.1	0.004	15.6	10.6	<.001
Public Places (n=1826)	35.2	38.7	39.3	38.3	25.0	<.001	30.7	43.4	<.001
Getting Services (n=1927)	37.2	32.9	42.4	38.9	30.3	<.001	36.5	38.4	0.17
Other Ways (n=279)	5.4	4.1	6.2	5.5	4.9	0.47	5.2	5.9	0.23
c. Burden and Skin-Color Determinants of Lifetime (Major Life) Discrimination									
Discrimination was more frequent (n=520)	10.74	21.8	14.6	9.0	9.2	<.001	11.8	8.9	0.004
Discrimination made life very stressful (n=1098)	22.7	14.1	19.4	24.1	23.7	<.001	25.0	18.6	<.001
Discrimination interfered w/having full life some to a lot (n=1793)	35.7	20.1	32.3	37.6	37.5	<.001	33.3	40.1	<.001
Discrimination made life hard some to a lot (n=1996)	39.8	23.5	36.4	42.2	40.5	<.001	38.2	42.7	<.001
Because of skin color, treatment by Whites was worse (n=674)	13.1	15.4	15.1	13.8	9.7	<.001	11.3	16.3	<.001
Because of skin color, treatment by Blacks was worse (n=773)	14.2	14.5	14.4	14.3	14.0	0.42	15.1	12.7	0.02

Source: Jackson Heart Study, baseline data 2000-2004.

Barbara V. Howard

This document summarizes a major research project funded by the National Heart Lung and Blood Institute of the NIH called the Strong Heart Study that has worked with American Indian communities to understand cardiovascular disease and its risk factors.

Goal and Principles

In partnership with community leaders and members to conduct excellent scientific studies to learn information that will help to treat or prevent cardiovascular diseases (CVD – heart diseases, stroke, and circulation problems) in Indian communities:

- Almost all staff members in the three centers (AZ, OK and DK) are community members. Thirty-one American Indian MDs, PhDs and advanced-degree candidates have been investigators.
- No measures are made or analyses performed that are not in the consent forms that are approved by all 13 communities and signed by all participants. All data and samples are stored without personal identifiers either in our data-coordinating Center in OK or in our laboratories in DC or San Antonio. No data or samples are released without full approvals.

Strong Heart Study (SHS) 1989-2000

Four thousand, five hundred and forty-nine men and women 45-74 years old (1,500 from GRIC, SRIC and AkChin) underwent three exams to measure risk factors (blood pressure, blood measures, lifestyle questionnaires) and indicators of CVD (ECG, ultrasound of neck, heart and legs). Results were provided to each participant and summaries to their communities.

What We Have Found

Results demonstrated for the first time an increasing rate of CVD in Indian communities, mainly in persons with diabetes. Rates of coronary heart disease and stroke are both higher than other ethnic groups in the U.S. We measured preclinical disease using carotid ultrasound and echocardiography and found that there is much evidence of accumulating atherosclerosis and abnormalities in heart function. We also evaluated several important risk factors and determined that, in addition to age, male sex and diabetes, LDL cholesterol, blood pressure, and measures of kidney disease are important predictors.

Community Benefits

- Revision of IHS guidelines for treatment of cholesterol.
- An Indian -specific calculator to help providers estimate CVD risk in Indian patients.
- Increased attention to the importance of urine protein or serum creatinine measures in predicting CVD and the need for careful blood pressure control.

Current continued follow-up of the participants will emphasize learning more about strokes and heart failure that occur as people age.

Stop Atherosclerosis in Native Diabetics (SANDS Trial) 2002-2007

This is the first trial in Indian communities to test prevention strategies for CVD in persons with diabetes. Four hundred and ninety-nine diabetic men and women participated for three years (137 from AZ).

Their blood pressure and cholesterol were treated either to current guidelines or to lower targets. Study staff worked closely with care providers. Targets for LDL cholesterol and blood pressure were reached and maintained in the majority of participants, showing that proper algorithms and careful training can substantially improve delivery of care.

There was marked improvement in ultrasound measures of atherosclerosis (hardening of the arteries) in those with lower targets, and fewer CVD events in both groups

What We Have Learned

- The results established the value of controlling blood pressure and blood fats in all persons with diabetes.
- Lower targets can be safely reached in Indian patients and may be needed in those at high risk.

Community Benefits

- Data now available in American Indian patients on safety and effectiveness in of medications that control blood pressure and cholesterol.
- Increased awareness of the benefits of controlling blood pressure and blood fats in people with diabetes.

Strong Heart Family Study (SHFS) 2000-2010

Three thousand, seven hundred and seventy-six men and women over 15 yrs of age who were members of 94 families were examined (1,279 in AZ, 31 families) using the same methods as SHS. Results are provided to each participant and summaries to their communities.

A genetic map was made (no cells were grown and no genomes were multiplied) and a search is ongoing to identify genes that determine CVD risk factors or are related to the ultrasound measures of the heart and of neck vessels. Continuous education on the meaning and value of genetic studies has resulted in this being well received by participants.

What We Have Learned

- Overweight in young people is already accompanied by increases in risk factors such as blood pressure and blood fats and also by abnormalities in the ultrasound measures of the heart.
- Depression is occurring in persons with diabetes and this may interfere with controlling blood sugar.
- The genetic maps have shown some promising areas that seem to control blood pressure and blood fats and may be related to body weight.

Community Benefits

- The findings in overweight young people have led to increasing attention to measuring CVD risk factors in young people who are overweight or have diabetes.
- Our work on depression is stimulating care providers to learn to identify and help persons who are depressed so that they can care for themselves better.
- Genetic work takes a long time to get to the point where exact genes and proteins are identified that can be turned into new treatments or ways to identify persons at risk, but this is our ultimate goal.

Current work is focusing on better understanding changes in risk factors and heart function throughout the lifespan, and analyzing the relations of lifestyle changes to CVD risk.

The Message

Emphasis has been on doing high quality science to obtain valid information that will be useful to care providers or for the development of new prevention and treatment regimens. Findings -- because this has been done in partnership with the community -- result in increased awareness and understanding of health problems. Communities will then be better equipped to plan health programs. The trial demonstrated that appropriate CVD risk factor control can be achieved and maintained in primary care settings mediated by intermediate level providers who are members of the community. Our studies also point to the importance of identifying barriers to adherence to prevention and treatment regimens and developing community based programs to address these barriers.

Bruce Siegel

Quality of Heart Care Can Be Improved – and Disparities Reduced

The United States spends twice as much money per person on health care than anywhere on earth, but the U.S. ranks 18th worldwide in average life expectancy – behind Australia, Canada, France, Japan and others. Given that America spends so much more money on health care, one would hope that Americans have better health outcomes than anyone else, so why the gap?

Most experts say that the answer lies in the quality of care Americans receive. Unfortunately, more care doesn't always mean better care or the right care. Americans receive a lot of health care treatments, but far too often, they are not the treatments that are proven to be most effective for the most people when applied at the right time, without mistakes.

Although the quality of health care is poor for many Americans, certain racial and ethnic groups continually experience worse quality care than white patients. While quality sometimes differs depending on the patient's geographic location, education level or health insurance status, repeated research has shown that African-Americans and Hispanics consistently receive a lower quality of care than their white counterparts, even when all demographic and socioeconomic factors are equal.

It's also proven that disparities in care don't stop once patients leave the hospital. Data suggest that gaps in health status emerge after patients of different racial and ethnic groups are discharged. Clearly, there is much to be done to improve the quality of care that minorities receive in and out of the hospital.

Identifying and reducing disparities in the quality of U.S. health care is a matter of some urgency – and survival for many hospital systems. The U.S. Census Bureau recently reported that minority populations in the U.S. will collectively outnumber whites in less than 35 years. Experts say that if hospitals are going to remain cutting edge and competitive in the future, they will need to be able to document that all patients receive the same care, regardless of skin color or background.

Cardiac Care – An Excellent Starting Point

In 2002, the well-respected Institute of Medicine's groundbreaking report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, provided evidence that racial and ethnic disparities in care were especially likely to occur in the treatment of cancer and heart disease. It's well documented, for example, that African-Americans and Hispanics are less likely than whites to receive life-saving cardiac diagnostic procedures, revascularization and thrombolytic therapy.

While a growing body of evidence documents potential underlying causes of disparities in care, little has been done to date to implement and test possible interventions to reduce or eliminate these gaps. Many experts believe that cardiac care is an excellent starting point. Whether experiencing a heart attack, heart failure or other conditions, the recommended standard of care for cardiac patients is clear and accepted among medical professionals nationwide, meaning that "the right thing to do" for most cardiac patients is widely

understood. Additionally, the measurement tools to determine whether cardiac patients received the recommended standard of care have been developed and thoroughly tested, so it's possible to tell if patients received the right care at the right time.

The Project: Expecting Success

In response to the lack of potential disparities solutions, the Robert Wood Johnson Foundation introduced a 29-month-long pilot program in late 2005, aimed at analyzing racial and ethnic disparities in cardiac care at select hospitals across the country. Called Expecting Success: Excellence in Cardiac Care, the program selected 10 pilot hospitals (from a competitive applicant pool of more than 120) to develop and share tools for improving cardiac care for African-American and Hispanic patients with acute myocardial infarction (AMI) or congestive heart failure (HF). The 10 general, acute-care facilities were intentionally diverse in terms of size, geographic location and hospital type – so as to ensure that their learnings would be adaptable and adoptable by hospitals nationwide. What they held in common was: a large base of African-American and/or Hispanic patients, a willingness to discover where and how disparities may be occurring, a proven track record in quality improvement initiatives, a readiness to serve as “learning laboratories” for other institutions nationwide and leadership committed to improving cardiovascular care for all patients, particularly minorities.

The Expecting Success participating hospitals focused on the continuum of cardiovascular care with four goals:

1. To improve cardiovascular care for African-Americans and Latinos;
2. To develop effective, replicable quality-improvement strategies, models and resources;
3. To encourage the spread of those strategies and models to clinical areas outside of cardiac care; and
4. To share relevant lessons with health care providers and policy makers.

The participating hospitals' multidisciplinary teams worked together via a collaborative “Learning Network” managed by a National Program Office that operated from The George Washington University Medical Center's School of Public Health and Health Services. Each hospital's efforts were led by a core team representing a wide variety of backgrounds – from chiefs of cardiology to frontline nurses to directors of quality improvement. The hospitals received modest grants for their participation and ongoing technical assistance. Over time, while simultaneously working to improve the quality of care for all of their heart patients, the hospitals were able to identify if there were racial and ethnic disparities in the care they were providing.

Hospitals Tracked Care Quality with Performance Measures

Throughout the Expecting Success project, the hospital teams provided monthly reports on 23 different care performance measures – all stratified by patient race, ethnicity and primary language. These included the eight core measures of care for heart attacks or acute myocardial infarction (AMI), and four core measures for heart failure (HF) that the U.S. Centers for Medicare and Medicaid Services collects and publicly reports. In addition, the hospitals reported on key composite measures – known as Measures of Ideal Care – showing

whether a given patient receives all of the core components of care they are eligible to receive as prescribed by the American College of Cardiology and the American Heart Association as evidence-based guidelines for the treatment of heart failure or heart attack. Most of the measures reflected the quality of inpatient care, but because Expecting Success was simultaneously focused on improving outpatient cardiac care, participating hospitals also reported their 30-day readmission rates as an additional performance measure.

Hospitals Measured Care by Patient Race, Ethnicity and Language

All hospital leaders like to believe that their institutions provide equal care regardless of a patient's race, ethnicity or primary language, but few know for certain. Without uniform standards for collecting this information (most registration staff simply "eyeball" patients and make a determination) and without tracking patient race and ethnicity data against quality measurements, there is no way of knowing if all patients receive the same level of care.

The Expecting Success hospitals each utilized the Health Research and Educational Trust toolkit to establish standardized collection of race, ethnicity and language patient data. Some of the hospitals made select modifications to tailor the tools for their staff. The cornerstone of each involved directly asking patients to self-report their race, ethnicity and language so that all of the patient's care could ultimately be compared with these demographics. At first, staff registration management and even senior hospital leadership expressed anxiety about whether collecting such data was legal, whether their computer registration systems would need to be completely overhauled and how patients would react to such questions about their race and ethnicity.

The process went considerably more smoothly than anticipated. The hospitals soon found that such data collection is legal; information technology departments were engaged early; and people are relatively accustomed to being asked demographic questions in many aspects of their everyday lives.

For the first time ever, the hospitals analyzed 23 cardiac care quality indicators by patient race, ethnicity and language. They faced the tough reality that disparities in care might exist in their institutions, but armed with this information, have made tremendous progress toward reducing these gaps in care.

Hospitals Designed Interventions to Improve Quality of Care

For the first year of the program – while a significant amount of data on race, ethnicity and language preferences of patients was being generated – the hospitals focused on developing interventions and putting systems in place to ensure that their heart patients would consistently receive all of the recommended care for their condition. Comparing data on the core measures before and after interventions were applied helped hospitals gauge how effective their interventions were and gave them the momentum to continue their work as planned, or adapt the intervention to be more effective.

Transitions in Care

Transitions in care for minority patients were closely tied to many of the disparities encountered during Expecting Success. As part of the program, hospitals realized the great

benefits of inpatient and outpatient centers coming together to learn from each other. Moving between the hospital and ambulatory care settings, minority patients were more likely to experience serious lapses in their path to recovery. Expecting Success promoted a disintegration of silos between the care settings and challenged them to work together.

Since many factors inhibit patients from following and managing their care once discharged, leaders at Expecting Success hospitals are now taking more time to talk with cardiac patients about their transition care plan long before discharge, so potential problems are identified prior to discharge and to prevent readmission. Hospitals often found that their ambulatory care centers had very successful programs in place that could be leveraged and used with patients in the hospital prior to discharge. Successful improvements to transitions in care include:

- Assess the transition points in the hospital.
- Ensure that existing transition procedures are being consistently followed.
- Assess if other procedures or resources exist to improve transitions.
- Coordinate the transition with all relevant inpatient staff.
- Discuss the transition and care plan with patients before discharge.
- Develop patient-centered, take-home resources to provide support during transitions.
- Proactively check on the status of patients after discharge and during transition.

Interpreting the Results

Final data from Expecting Success awaits peer-reviewed publication, but preliminary results show that the program had a remarkable effect in a short period of time. Key results show:

- The all-hospital median heart failure Measure of Ideal Care, an indicator that a patient received all the recommended standards of heart failure care eligible to receive in the hospital, had a significant increase from 41 percent to 78 percent over two years.
- The all-hospital median Measure of Ideal Care score for heart attack patients, an indicator that a patient received all the recommended standards of heart attack care eligible to receive in the hospital, increased from 74 percent to 86 percent over two years.

The hospitals participating in the pilot phase of Expecting Success achieved core goals of the program, and many are actively applying the program's principles to areas of care for other conditions. Among their accomplishments:

- *Recognized disparity in disease treatment.* Through the Expecting Success program, hospital management and clinicians became increasingly aware that the potential for racial and ethnic disparities existed at their institution and became more firmly committed to identifying whether disparities existed and addressing them promptly. Recognizing that black and Hispanic patients appear to face a greater burden in consistently receiving high-quality care in their institutions was a huge eye opener for some participants.
- *Improved quality; reduced disparities.* Within one year, every hospital that participated in the program was increasing its percentage of patients receiving all core measures of care recommended for heart attacks and heart failure. The successes continued throughout the program.
- *Hardwired uniform collection of patient race, ethnicity and language data.* For the first time, participating hospitals tracked data on core measures of care for patients with heart failure or who had a heart attack by race, ethnicity and primary language. While

simultaneously working to improve the quality of care for all their heart patients, the hospitals were able to identify if there were racial and ethnic disparities in their care.

- *Implemented targeted quality improvements based on data.* The hospitals identified and implemented ways to ensure that patients consistently received the right care developing standard order sets, creating documentation systems, etc. At each hospital, this required a team approach to identify where proven quality standards were being missed, and to redesign systems accordingly.
- *Implemented targeted quality improvements based on data.* The hospitals identified and implemented ways to ensure that patients consistently received the right care – developing standard order sets, creating documentation systems, etc. At each hospital, this required a team approach to identify where proven quality standards were being missed, and to redesign systems accordingly.
- *Became more engaged in discharge and outpatient care to reduce readmissions.* Quality of care after hospital discharge proved to be dramatically different for patients of different races/ethnicities. Expecting Success hospitals all recognized that they have considerable work to do with providers and clinics in their communities to better manage their cardiac patients after they leave the hospital, in order to prevent unnecessary readmissions and emergency department visits.

Spreading the Success to Other Institutions

Working together, the Expecting Success collaborative helped participating hospitals improve the overall quality of their cardiac care, explore whether disparities in their care exist and summon the courage and tools to address the findings. Success was contingent upon the hospitals knowing exactly who their patients were and identifying whether these patients received the same care regardless of race, ethnicity or language.

Hospitals that participated in the pilot program, along with staff from the National Program Office, believe key factors to implementing the program include:

- *Recognize the importance of talking about disparities.* No one wants to consider that their institution may have disparities, but acknowledgement that inequities may exist is the first step to gathering and following the data.
- *Garner executive buy-in for improving quality.* Develop a compelling case for management's support by showing that the hospital does not always meet evidence-based care metrics.
- *Engage all stakeholders.* Include senior leadership, information technology, quality improvement staff, all levels of clinical staff, frontline registration staff and others in planning the program.
- *Build community awareness.* Tell the community what you're undertaking to showcase efforts and increase support.
- *Data collection is essential.* A consistent process for collecting patient data by race, ethnicity and primary language with everyone is instrumental to the success of the effort.
- *Creativity counts when improving quality.* All hospitals tried out a wide range of interventions in their effort to improve their progress on meeting core measures.

Expecting Success: Excellence in Cardiac Care

Bruce Siegel, MD, MPH
Director
Center For Health Care Quality

United States Commission on Civil Rights Briefing
June 12, 2009

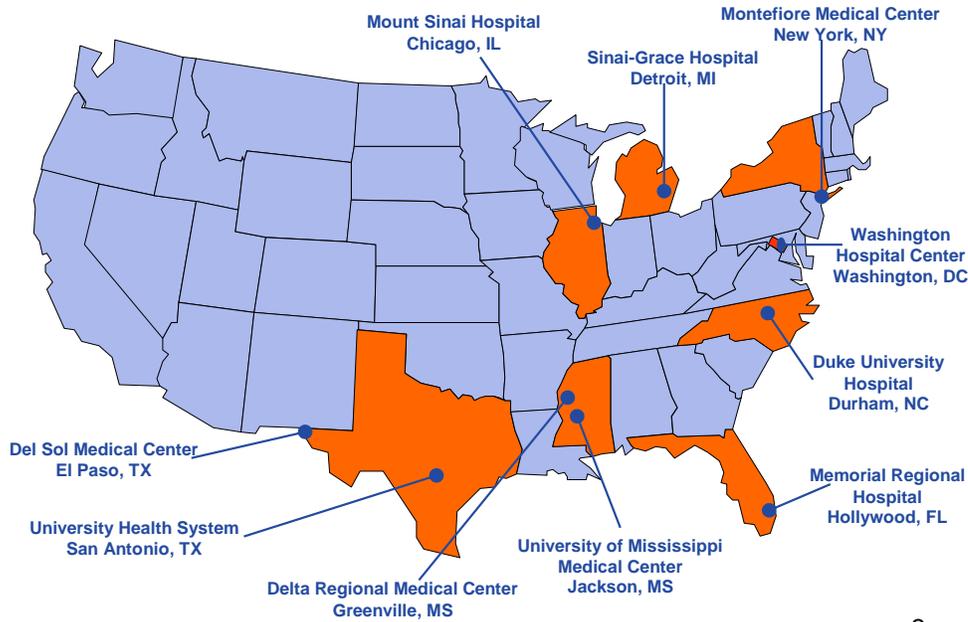


THE GEORGE WASHINGTON UNIVERSITY
SCHOOL OF PUBLIC HEALTH
AND HEALTH SERVICES

A hospital collaborative to eliminate disparities

- **Expecting Success:** Robert Wood Johnson Foundation-funded
- Built on IOM's *Unequal Treatment*
 - Evidence-based care to promote equity; reduce disparities
- Focused on improving cardiac care for African-Americans and Latinos
 - Heart attack and heart failure
- Major elements
 - Standardized collection of patient race/ethnicity/language data using **HRET Toolkit**
 - Quality improvement
 - Measurement: 23 quality measures reported monthly **by patient race, ethnicity and language**
 - Core measures, all-or-none measures, CHF 30 day-readmission rate

Expecting Success Partners



3

First step:

Collecting accurate data on patient race, ethnicity and language

- No more “eyeballing”: Ask at registration
 - Change information systems to capture data
- Lots of anxiety
- First time done in multi-hospital setting
- These hospitals now know who their patients are
 - One hospital and Hispanic patients

4



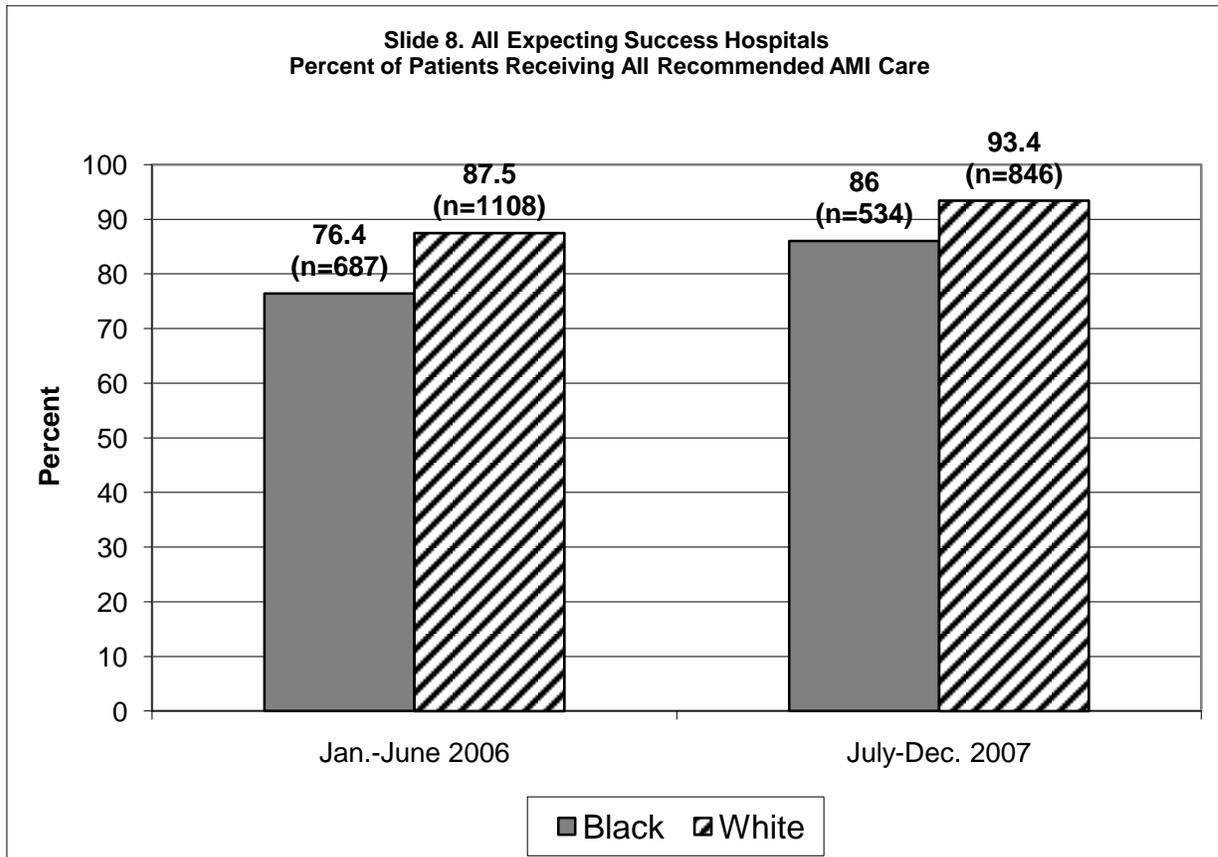
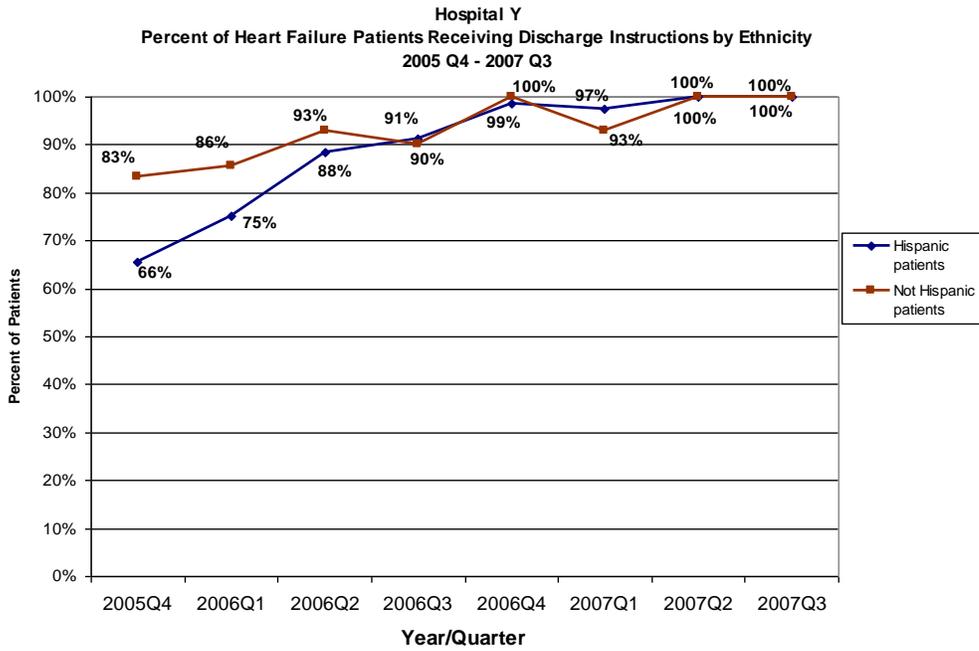
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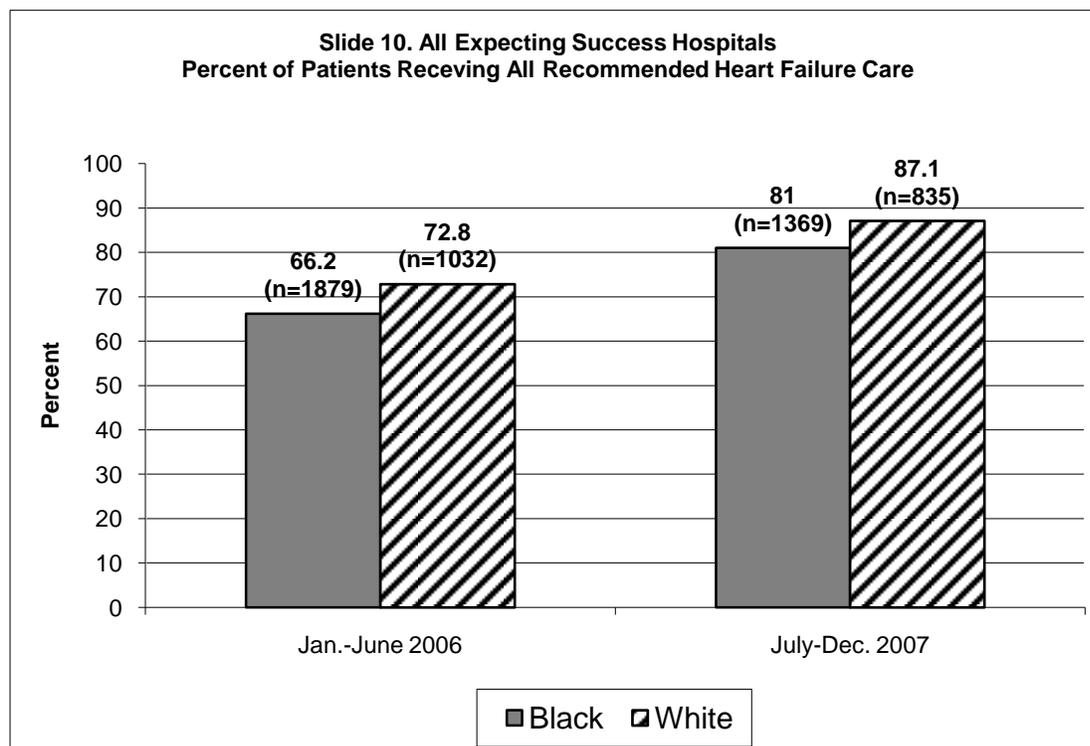
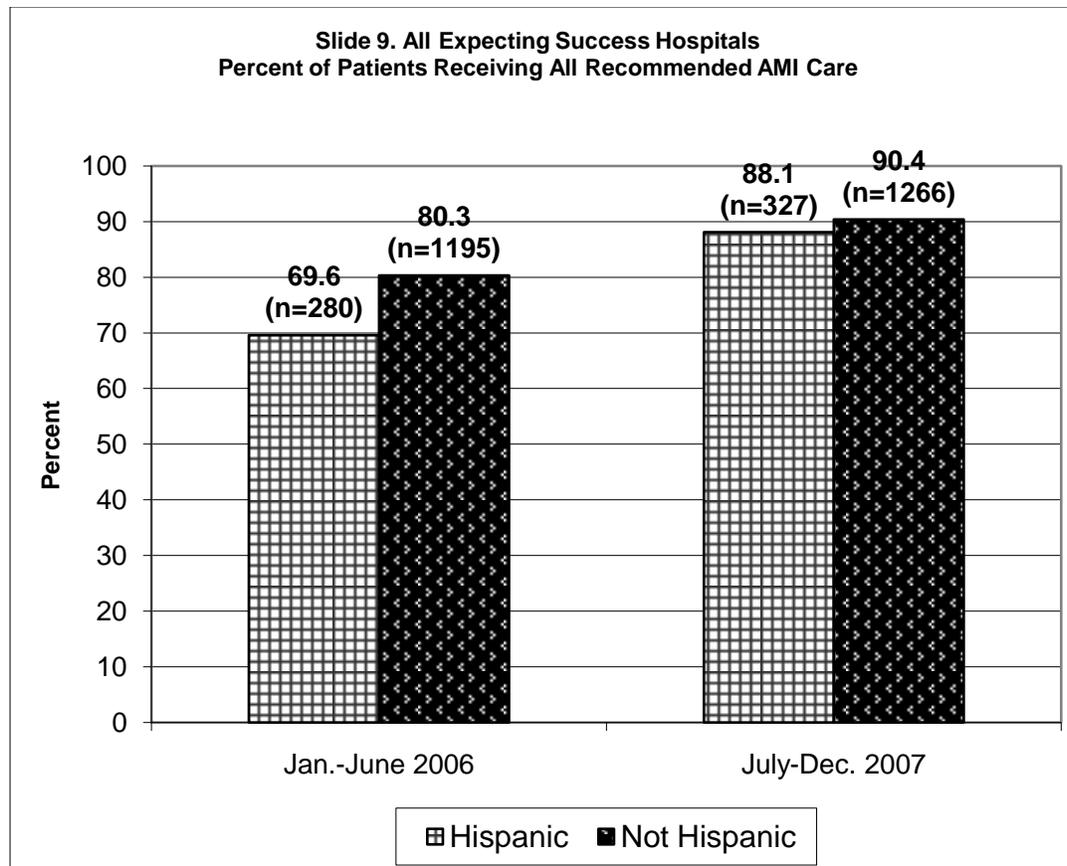
Quality focus

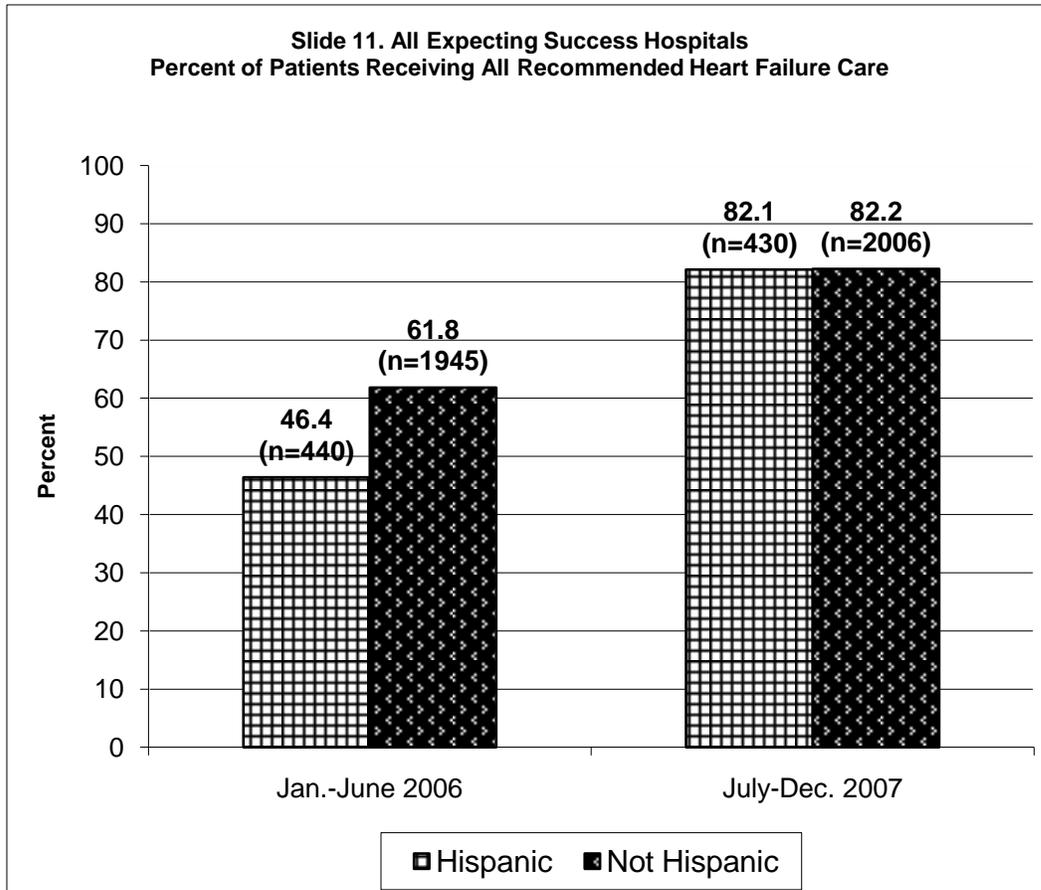
- Three major improvement “themes”
 - *Ensuring evidence-based care*
 - Standard order use
 - *Redesigned Processes*
 - “Code Heart” to reduce time to care for heart attack patients
 - *Discharge and transition*
 - Heart failure educators

6

Closing the gap







The bottom line:

- Gaps can be closed
- High-minority hospitals can dramatically improve care
- A journey of self-examination
 - One hospital’s experience with black/white disparities
- But what happens after the patient goes home?

R/E/L data collection and the law

- ❑ An increasing number of states mandate the collection and reporting of R/E/L data from certain providers or plans.
- ❑ Medicare will begin collecting quality data by race, ethnicity, and gender from providers within 2 years.¹
- ❑ It is legal to report de-identified data by R/E/L for quality improvement purposes
- ❑ It is legal for providers and plans to collect this data in most circumstances
 - Some states (CA, MD, NH, NJ, CT, MN, SD) prevent some types of insurance plans from collecting this data at the time of application for insurance coverage

1. Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Public Law 110-275, July 15, 2008

American Recovery and Reinvestment Act of 2009

- ❑ HIT provisions are incorporated as the Health Information Technology for Economic and Clinical Health (HITECH) Act
- ❑ Creates Office of the National Coordinator for Health Information Technology (ONCHIT) to develop and oversee a nationwide HIT infrastructure that improves health care quality and transparency of health information, and reduces costs, errors, and disparities
- ❑ HIT Policy Committee to make recommendations regarding the collection of race, ethnicity, primary language, and gender data
- ❑ HIT Standards Committee to recommend standards, implementation specifications, and certification criteria consistent with policy recommendations

Public Comments

In addition to the written and oral testimony presented at the briefing, some individuals and organizations contributed statements to the Commission for inclusion in the public record. Below is a summary of the highlights of the public record outside of the testimony of the panelists.

Minority Lawmakers Want Bill To Close Health Gaps

Ben Evans

The Washington Post

Tuesday, June 9, 2009

Racial and ethnic minority lawmakers warned Democratic leaders that any health care legislation that does not address health gaps between whites and minorities will be opposed. Republicans are resisting a government health insurance program that would compete with private insurance companies, arguing that the companies would be put at a competitive disadvantage.

Members of the Asian, Congressional Black and Congressional Hispanic Caucuses plan to introduce legislation this week that would broaden health care reform beyond those plans already floating in the House and Senate. The three minority caucuses have a total of 91 members, most of whom are Democrats, which is enough to help mold the final piece of legislation. Because of higher rates of cancer, diabetes, heart disease and infant mortality among minorities, minority lawmakers want more funds for community health centers that provide care in poor neighborhoods. They also want to expand a National Institute of Health center to focus on minority health concerns, work to improve workforce diversity in the medical industry and collect additional data to better track disparities in health care.

Health and Human Services Secretary Kathleen Sebelius said the Obama administration is committed to addressing the “alarming disparity in the delivery of quality health care,” which is critical to lowering health care costs. According to Secretary Sebelius, 75 percent of the nation’s \$2.2 trillion health care expenses go toward treating chronic diseases, which are more prevalent among minorities. She noted that increasing rates of HIV/AIDS among African-Americans is one of the most disturbing events in U.S. health care.

Secretary Sebelius also noted that not only are minorities more likely to be uninsured, but are also less likely to receive quality care. According to a White House issued summary report on minority health care, one in three Hispanics and American Indians, and roughly one in five African-Americans as compared to one in eight whites lack health insurance. The report also shows that African-Americans are seven times more likely than whites to have HIV/AIDS, that blacks and Hispanics have diabetes rates nearly twice as high as whites, and that black men are 50 percent more likely than their white counterparts to develop prostate cancer.

Racial Disparities in Illness Highlighted – Study Finds Alarming High Rates Among Black Women

Darryl Fears

The Washington Post

June 10, 2009

According to a Kaiser Family Foundation study released today, black women in Washington, D.C. are more likely than their white counterparts to suffer from obesity, diabetes, heart disease and poor health in general at alarming rates. The study was based on 2004 to 2006 data compiled by the Centers for Disease Control and Prevention and the Current Population Survey. Unless otherwise stated the statistics in this story pertains to Washington, D.C. The study also found wide gaps between black and white women in incidences of cancer and HIV/AIDS and noted that black women's poor health is associated with low educational attainment, poverty, unemployment, stress, bad living conditions and inadequate health care coverage. Twenty-five percent of black women live below the poverty line, which was defined as \$19,000 a year for a family of four at the time of the study, and nearly 14 percent of black women had no high school diploma.

The study showed that black women's health also compared unfavorably with that of other minority women. For example, 36 percent of black women compared with 10 percent of Hispanic and Asian women were overweight or obese; and more than 7 percent of black women suffered from diabetes as compared with only 2 percent of Hispanic and 3 percent of Asian women. Less than 1 percent of white women suffered from diabetes and only 7 percent were overweight or obese. Cara James, a senior policy analyst at the Kaiser Foundation, acknowledged that comparing black women's health with that of white women in Washington, D.C. is rather unfair because the city's white women tend to be among the healthiest and wealthiest in the nation.

According to the Kaiser Foundation study, the health disparities between black and white women were narrower in Maryland and Virginia. In Maryland, 37 percent of black woman compared with 21 percent of white women were overweight or obese. In Virginia, the rate was 36 percent for black women and 17 percent for white women. In the District, the cancer mortality rate was 204 per 100,000 black women and 137 per 100,000 white women. In Maryland, the cancer mortality rate was 191 per 100,000 black women compared with 166 per 100,000 white women. In the District, the incidence of new HIV/AIDS infection for black women, 176 per 100,000, was far larger than for any other group of women. The rate for Hispanic women was 48 per 100,000.

According to a District of Columbia study, the city's overall AIDS prevalence rate was 3 percent, the highest in the nation. In Virginia and Maryland the rates were 31 per 100,000 and 68 per 100,000, respectively. The District of Columbia's health director, Pierre Vigilance said the city is working to address the disparities and more is being done to address access to more health care for women, and especially mothers.

Speaker Biographies

Peter Bach

Peter Bach is a member of the Health Outcomes Research Group in the Department of Epidemiology and Biostatistics, and a pulmonary and critical care physician in the Department of Medicine in Memorial Sloan-Kettering Cancer Center. His work has focused on improving the quality of care for African-American patients in Medicare, including cancer care. Dr. Bach is also engaged in health care policy work. In 2005 and 2006, he served as senior adviser to the administrator of the Centers for Medicare and Medicaid Services (CMS) in Washington, DC, where he oversaw the agency's cancer initiatives, evidenced development work through conditional coverage, and data policy. He is the recipient of the Boyer award for clinical research, was the previous incumbent of the Frederick Adler faculty chair, and has been the recipient of grants from the National Cancer Institute, the National Institute of Aging, and the American Lung Association. Dr. Bach is a graduate of Harvard College, the University of Minnesota Medical School, and the University of Chicago School for Public Policy.

Amitabh Chandra

Amitabh Chandra is an economist and a professor of public policy at the Harvard Kennedy School of Government. He is a research fellow at the IZA Institute in Bonn, Germany, and at the National Bureau of Economic Research (NBER). His research focuses on productivity and cost-growth in health care and racial disparities in health care. His research has been supported by the National Institute of Aging, the National Institute of Child Health and Development, the Robert Wood Johnson Foundation, and has been published in the *American Economic Review*, the *Journal of Political Economy*, the *New England Journal of Medicine*, and *Health Affairs*. He is an editor of the *Journal of Human Resources*, *Economics Letters*, and the *American Economic Journal*. Professor Chandra has testified to the United States Senate, the National Academy of Science, the Institute of Medicine and the United States Commission on Civil Rights. His research has been featured in the *New York Times*, the *Washington Post*, CNN, *Newsweek*, and on National Public Radio. He is the recipient of an Outstanding Teacher Award, the first-prize recipient of the Upjohn Institute's International Dissertation Research Award, the Kenneth Arrow Award for best paper in health economics, and the Eugene Garfield Award for the impact of medical research.

Garth N. Graham

Garth Graham is the deputy assistant secretary for minority health in the Office of Minority Health at the Department of Health and Human Services (HHS). He also serves as the executive director of the HHS Council on Health Disparities. The Council is comprised of senior leadership across the department, which coordinates and tracks progress on disparities related projects undertaken by the department. He was previously appointed a White House Fellow and special assistant to former Secretary Tommy G. Thompson at the Department of Health and Human Services.

Dr. Graham founded the Boston Men's Cardiovascular Health Project, a project designed to identify behavioral explanations for decreased adherence to adequate diet and exercise by African-American men. Dr. Graham was the Founding Senior Editorial Board Member of the Yale Journal of Health, Law, Policy, and Ethics, served on the Editorial Board of the Yale Journal of Biology and Science, and was a reviewer for the Journal of Health Services Research. He also served on the Public Health Executive Council of the Massachusetts Medical Society, the Board of Directors of Physicians for Human Rights, chairman of the American Medical Association/MSS National Minority Issues Committee and on the Steering Committee of the Boston Men's Health Coalition. Dr. Graham has taught on the Faculty of the Observed Structured Clinical Exam at Harvard Medical School and has authored scientific articles and presentations on cardiovascular disease, HIV/AIDS, and community medicine and medical education.

Dr. Graham earned an M.D. from the Yale School of Medicine, where he graduated cum laude. He also earned an M.P.H. from the Yale School of Epidemiology and Public Health with a focus in health policy administration. Dr. Graham completed his residency in Internal Medicine at Massachusetts General Hospital and was also a Clinical Fellow at Harvard Medical School.

Barbara V. Howard

Barbara Howard is the senior scientist and former president of MedStar Research Institute. She was formerly the associate chief of the Phoenix Clinical Diabetes and Nutrition Section, NIDDK, National Institutes of Health. She is the past chair of the American Heart Association Council on Nutrition, Physical Activity, and Metabolism, past chair of the Nutrition Committee of the American Heart Association, and past chair of the Nutrition Study Section of the National Institutes of Health. She has served as a member of the NIH Expert Panel on Obesity that developed guidelines for the treatment and prevention of obesity, on ADA advisory panels to develop recommendations for management of lipids and glucose, and as a member of editorial boards for several scientific journals.

Dr. Howard has received the Bolton Corson Medal from the Franklin Institute for research in nutrition and atherosclerosis and the Special Recognition Award from the Arteriosclerosis Council of the American Heart Association. She was a Bierman lecturer for the American Diabetes Association, a Levy lecturer for the American Heart Association, and has received the Kelly West Award from the American Diabetes Association. Her major research interests are in cardiovascular disease, particularly in relation to diabetes and its occurrence in diverse ethnic groups. Her current research projects include the Strong Heart Study, a multi-center study of cardiovascular disease and its risk factors in American Indians; the Women's Health Initiative, a multi-center study of postmenopausal women and their health; GOCADAN, a study of the genetics of coronary artery disease in Alaska Eskimos; and the SANDS study, a multi-center study to examine strategies for reducing atherosclerosis in people with diabetes.

Dr. Howard received her Ph.D. in Microbiology from the University of Pennsylvania in 1968, and currently holds faculty appointments in the Department of Medicine at Georgetown University and the Department of Biochemistry at Howard University.

William R. Lewis

William Lewis is an attending physician at MetroHealth Medical Center, an affiliate of Case Western Reserve University, where he is also an associate professor of medicine and chief of clinical cardiology. He has served on the board of trustees of the Ohio Chapter of the American College of Cardiology and represented Ohio on the Board of Governors of the ACC. He is former president of the Cleveland Metro Division of the American Heart Association.

Dr. Lewis' main research interest is in health care quality. He has served on various ad hoc committees for the ACC and the Heart Rhythm Society and is a Fellow for the National Association of Public Hospitals Program. He also serves on the national Steering Committee for the American Heart Association's Get with the Guidelines program and has been a speaker for the program on a regional and national level.

Dr. Lewis received a Bachelor of Arts in economics and his medical degree from Ohio State University. He was inducted into the Gamma Chapter of the Alpha Omega Alpha honorary medical society, and for his research efforts, was inducted into the Landacre Society. He received his internal medicine training at University Hospitals of Cleveland and Case Western Reserve University. He is board certified in internal medicine, cardiology and clinical cardiac electrophysiology.

Rubens J. Pamies

Rubens Pamies is the vice chancellor for academic affairs, dean for graduate studies and professor of internal medicine at the University of Nebraska Medical Center (UNMC). Prior to that, he was chairman of the department of internal medicine and The Edward S. Harkness Professor of Medicine at Meharry Medical College School of Medicine. He was chief of service in the department of internal medicine at the Metropolitan Nashville General Hospital, and he was a professor of medicine in the School of Medicine at Vanderbilt University Medical Center. Dr. Pamies was recently selected as a new member and chair of the Advisory Committee on Minority Health for the U.S. Department of Health and Human Services' Office of Minority Health. He collaborated with former United States Surgeon General, Dr. David Satcher, to author and edit one of the first textbooks addressing inequalities in health care titled, "Multicultural Medicine and Health Disparities." Dedicating his academic medical career to minority health issues, Dr. Pamies created the first office of minority affairs at the University of South Florida College of Medicine in 1991. He also served as chief of the general internal medicine division at Mount Sinai Medical Center in Cleveland.

Dr. Pamies is a contributor to the Institute of Medicine's report for research and reducing health disparities. He is a test committee representative for the National Board of Medical Examiners, chairman of the Building Bright Futures adolescent behavioral health task force in Omaha, and a formal member of the Public Health Advisory committee for the Congressional Black Caucus Foundation, Inc.

Dr. Pamies received his baccalaureate degree in 1981 from St. John's University and his medical degree in 1986 from the State University of New York at Buffalo. He completed his residency at Cornell-North Shore University Hospital in the internal medicine primary care track.

Sally L. Satel

Sally Satel is a resident scholar at the American Enterprise Institute and former W.H. Brady Fellow. She is also a staff psychiatrist at the Oasis Clinic in Washington, D.C., and a lecturer and assistant professor of psychiatry at Yale University School of Medicine. Dr. Satel was professional staff on the U.S. Senate Veteran's Affairs Committee. She has also held positions as a staff psychiatrist with the District of Columbia Superior Court Pretrial Program and West Haven VA Medical Center, Yale University School of Medicine. She is a former member of the Advisory Council at the U.S. Department of Health and Human Services, Center for Mental Health Services and the U.S. Department of Defense, Panel to Investigate Sexual Misconduct at the U.S. Air Force Academy.

Dr. Satel has authored several books and monographs, including *Drug Treatment: The Case for Coercion* (AEI Press, 1999); *PC M.D. - How Political Correctness is Corrupting Medicine*. (Basic Books, 2001); *Health and the Income Inequality Hypothesis: A Doctrine in Search of Data* (AEI Press, 2004) with N. Eberstadt; *The Health Disparities Myth: Diagnosing the Treatment Gap* (AEI Press, 2006) with J. Klick; *One Nation under Therapy How the Helping Culture Is Eroding Self-Reliance* (St. Martin's, 2005) with C. Sommers; and *When Altruism Isn't Enough: The Case for Compensating Kidney Donors* (AEI Press, 2008).

Dr. Satel received her Bachelors of Science degree from Cornell University; Masters of Science degree from the University of Chicago, and M.D. from Brown University, Providence.

Bruce Siegel

Bruce Siegel is a research professor and director of the Center for Health Care Quality in the Department of Health Policy at the George Washington University School of Public Health and Health Services. There he oversees the Aligning Forces for Quality Initiative of the Robert Wood Johnson Foundation. Much of his work has sought to measure and improve the quality of health care received by Americans, with focus on its most vulnerable populations. His contributions have included developing innovation in reducing crowding and improving hospital patient flow, eliminating ethnic and racial disparities in care, and supporting the safety net. Dr. Siegel's research projects have included work with the Commonwealth Fund, the California Endowment, the Agency for Healthcare Research and Quality, the District of Columbia and others on quality and equity.

Dr. Siegel has previously held the positions of New Jersey Commissioner of Health, president of the New York City Health and Hospitals Corporation, and president of Tampa General Healthcare. In addition, he served as a director of the Accreditation Council for Graduate Medical Education, as a senior fellow at New School University, and as an advisor

to the Institute of Medicine, the World Bank, hospitals, hospital associations, philanthropies, count and state governments, and pharmaceutical firms. He is a member of the Board of Stewardship Trustees of Catholic Health Initiatives.

Dr. Siegel received his AB degree from Princeton University, MD from Cornell University medical College, and MPH from Johns Hopkins School of Hygiene and Public Health. He is board certified in Preventive Medicine. He has written and spoken extensively on health care management, policy and public health issues.

Louis W. Sullivan

Louis Sullivan is chairman of the board of the National Health Museum in Atlanta, Georgia, and is also chairman of the Washington, D.C., based Sullivan Alliance to Transform America's Health Professions. Additionally, he serves as chair of the President's Commission on Historically Black Colleges and Universities, and was co-chair of the President's Commission on HIV and AIDS from 2001-2006. Dr. Sullivan is the founding dean and first president of Morehouse School of Medicine (MSM). On July 1, 2002, he retired and was appointed president emeritus. In addition, he is former secretary of the U.S. Department of Health and Human Services (1989-1993).

Dr. Sullivan was an instructor of medicine at Harvard Medical School and assistant professor of medicine at Seton Hall College of Medicine and was co-director of hematology at Boston University Medical Center where he founded the Boston University Hematology Service at Boston City Hospital.

Dr. Sullivan received his undergraduate degree from Morehouse College and earned his medical degree, cum laude, from Boston University School of Medicine. He is certified in internal medicine and hematology, holds a mastership from the American College of Physicians and is a member of Phi Beta Kappa and Alpha Omega Alpha academic honor societies. Dr. Sullivan is the recipient of more than 55 honorary degrees, including an honorary doctor of medicine degree from the University of Pretoria in South Africa.

Herman A. Taylor

Herman Taylor holds positions at the three institutions that are partners in the Jackson Heart Study (JHS). In 1998, Dr. Taylor came to Jackson, Mississippi, to lead the JHS, the largest population-based study of heart and related diseases ever undertaken in African-Americans. While the study seeks to answer questions about cardiovascular disease risk in the African-American population, it also provides historically black colleges and universities experience in large-scale epidemiological research. Dr. Taylor attended Princeton University and then Harvard Medical School. After a year's internship at Harvard's Mount Auburn Hospital, he spent two years in the Miami, Florida, Liberty City neighborhood with the National Health Service Corps. After completing a residency in internal medicine at the University of North Carolina at Chapel Hill and a cardiology fellowship at the University of Alabama in Birmingham (UAB), he was appointed to the UAB faculty and served as attending cardiologist at the University Hospital, the Birmingham Veterans Medical Center, and the

Cooper Green Hospital. At UAB, Taylor was the first African-American chief cardiology fellow and the first black cardiologist on the faculty. He was the founding Medical Director of the UAB Hospital Cardiopulmonary Rehabilitation Service and was lead investigator on several studies funded by the National Institutes of Health (NIH). He also founded Heart to Heart (HTH), a non-profit organization that provides cardiac surgical services for children from the developing world. Dr. Taylor is listed as one of the Best Doctors in America, and in 2005, he was named the first Aaron Shirley chair for the Study of Health Disparities at the University of Mississippi Medical Center.

Commissioner Statements

Statement of Abigail Thernstrom, Vice Chair

Are Differences in Health Care Due to Racial Discrimination?

Many Americans do not enjoy good health care. And when the data on quality of care and health outcomes are sorted by race, ethnicity, geography, income, education, as well as a host of other variables, it becomes clear that some groups are served less well than others by the American health care system. But are the disparities in quality care due to racial discrimination? Our briefing did not definitively answer that question.

As our panelists pointed out, if we are to improve the health care system, we need to consider the many factors that contribute to the troubling group differences.

Americans deserve the best medical care possible without regard to race, gender, or ethnicity. It is within the purview of our civil rights enforcement agencies to protect all Americans against racially discriminatory practices. But disparities, in and of themselves, are not evident of illegal discrimination.

During our briefing the subject of cultural competence training for medical professionals was raised by two panelists,¹ and it was addressed again by me² during our Q & A.

Dr. Sally Satel described the definitions of cultural competence as mind numbingly vague.³ In her testimony she echoed my biggest concern:

At its worst, cultural competency training devolves into a version of racial sensitivity training with the stereotypes intact. I've always wondered how I'm supposed to treat black patients differently than white ones.⁴

Dr. Peter B. Bach added:

We should appreciate that medical education is a zero sum game...every layer of demand [such as adding cultural competence training] we put on [medical students] academically to enrich their ability in one area necessarily takes away from some other area.⁵

¹ Prepared statements submitted for the 6/12/2009 USCCR briefing by both Dr. Sally Satel and by Dr. Graham Garth.

² Vice Chair Abigail Thernstrom questions about cultural competence 6/12/2009 at USCCR draft briefing transcript pp. 88-98, with responses from various panelists.

³ Dr. Sally Satel testimony 6/12/2009, USCCR draft briefing transcript at p. 96.

⁴ Dr. Sally Satel testimony 6/12/2009, USCCR draft briefing transcript at p. 96.

⁵ Dr. Peter Bach testimony 6/12/2009, USCCR draft briefing transcript at p. 85.

Dr. Satel, citing the work of Joseph Betancourt, delivered the simplest, most cogent definition of “cultural competence” in the medical setting:

This is about universal factors in dealing with other human beings, in this case within the medical setting, and it’s a very short quotation where [Betancourt] says that an enlightened form of cultural competence...has “evolved from implementing the principles of patient center[ed] care, including exploration, empathy, responsiveness to patients’ needs, values and preferences.”⁶

Dr. Satel also made a very useful distinction between linguistic competence and anthropological competence. The first involves overcoming language barriers, while the second involves awareness of the differences in custom and practice between the health care provider and the patient. The latter might include, for example, knowing that kinds of home remedies a particular patient from a different culture might be using, or the unique dietary habits of patients from that culture.⁷

In her prepared statement, Dr. Satel also remarked on the waning focus on classic discrimination – on group prejudice. “It is my impression,” she said

that the tenor of the discussion surrounding health disparities has softened in the media, especially with respect to the notion that physicians themselves are prejudiced. Nowadays, the more generally accepted view is that wider, more systemic factors underlie health differentials. There is less overt talk of “racism” or “bias.”⁸

Of course some physicians are undoubtedly prejudiced against members of certain groups, but their numbers are surely small, and it would seem more useful to focus training on bridging the linguistic and cultural gaps that can interfere with the practices of good medicine.

Finally, our panelists identified many intervening variables affecting the quality of health care that should be addressed in a systematic fashion. In addition to addressing problems created by cultural and linguistic barriers, these variables included: Resources (facilities, the number of board certified doctors, budgets); lifestyle problems that span cultures (poor dietary and exercise habits, for instance); inadequate patient education and outreach; and poor quality health care in rural areas.

⁶ Dr. Sally Satel testimony 6/12/2009, USCCR draft briefing transcript at p. 97.

⁷ Dr. Sally Satel testimony 6/12/2009, USCCR draft briefing transcript at p. 96.

⁸ Dr. Sally Satel prepared statement 6/12/2009, at page 4.

Statement of Commissioner Todd Gaziano

I am pleased to join the concurring Statement of Commissioner Gail Heriot.¹ Her statement provides an excellent summary of the evidence gathered by the Commission refuting the claim that individual doctors treat their white patients differently than their minority patients; the principal reason for health care disparities relates to differences in the quality of care in different areas of the country. Commissioner Heriot's statement also powerfully explains why well-meaning efforts to artificially increase the number of minority health care providers and promote "cultural competency" training are likely to backfire.

My separate effort attempts to explain the central finding of the research she discusses with some simple examples and to briefly summarize the legal consequences that flow from that research. My focus is as follows: (1) among the many complex causes of health (and health care) disparities, intentional or subconscious discrimination based on race or ethnicity does not appear to be a measurable component—it appears not to exist; and (2) the absence of racial or ethnic discrimination renders most attempts by government to legislate preferences for minority health care professionals both counterproductive and unconstitutional.

In parts of southern West Virginia, not too far from where I grew up and my father still practices medicine, the health status and treatment options for many poor residents are heartbreaking. The grim situation these residents face is caused by a mix of factors: increased stress from poverty and high unemployment; significantly higher levels of obesity, caused in part by cultural influences and low income (obesity and an unhealthy diet tend to be inversely related to income); lower quality health care facilities and fewer means to obtain health care; a slight fatalism from previous generations of isolation and hardship that causes them to seek preventative care or early medical intervention less frequently; and other conditions prevalent in the area (such as occupational lung disease from a deadly combination of smoking and decades of work in underground coal mines).

Appalachia has some unique problems, but similar factors that influence health outcomes are not evenly distributed among racial and ethnic groups throughout America. Apart from some rare genetic predispositions to diseases that correlate with race, most causes of health disparities are not related to the race or ethnicity of the patients themselves or their doctors, but to the conditions in which they grow up and live. Unfortunately, some racial and ethnic populations are more poorly situated than others. Thus, aggregate statistics about differences in relative health measured by race or ethnicity don't communicate much that is helpful, and probably do much to mask the real causes of the disparities.

¹ See also Letter from the U.S. Commission on Civil Rights to President Barack Obama and Distinguished Member of Congress, October 9, 2009, available at www.usccr.gov/correspd/CommissionHealthCareBill100909.pdf, regarding similar issues relating to the then pending health reform bill (the letter was signed by Commission Chairman Gerald Reynolds and Commissioners Pete Kirsanow, Ashley Taylor, Gail Heriot, and myself).

With regard to health treatment disparities, it should surprise no one that medical treatment options are based at least in part on the quality of the health care facilities and providers in a given community. Practitioners in many suburban and urban areas are better credentialed, have more advanced equipment, and have more specialized practices, on average, than elsewhere. Moreover, certain advanced procedures are pioneered in teaching hospitals and have the highest success rate when administered by physicians who perform them regularly. Residents served by many rural health care facilities simply have fewer health care options.

As Commissioner Heriot's statement explains, there is little evidence that individual doctors (regardless of race) treat their minority patients worse than their white patients.² There are many factors that contribute to health treatment disparities, but intentional or subconscious discrimination does not seem to be one of them. The best evidence shows that there is little or no difference in treatment by race or ethnicity within a particular health care facility. Unfortunately, minority populations are overrepresented in the regions of the country with poorer health facilities.³ Similarly, minority patients are more likely to be served by lower-performing hospitals than are white patients.⁴ The best way to improve health care for minority patients would be to improve the quality of the facilities and professionals in areas where they live.

These findings have significant legal consequences for policymakers. The starting point for any analysis of race-conscious policies is that *all* race-conscious policies of any kind, including those that attempt to mitigate health disparities, are presumptively unconstitutional. As the Commission noted in its October 9, 2009 letter on the health care bill, all governmental racial classifications (whether well-meaning or not) trigger strict scrutiny, the most intensive type of judicial review.⁵ To survive strict scrutiny, a regulation must be necessary to achieve a compelling government purpose and must be the most narrowly tailored means to accomplish that end.⁶ It is very unlikely that any race-conscious policy could overcome the strong presumption of unconstitutionality because the factors discussed above would cause any conceivable race-based policy to flunk the Supreme Court's strict-scrutiny test.

² Statement of Amitabh Chandra; Statement of Sally L. Satel (describing studies showing physician's race had little to do with how black patients fared).

³ Statement of Sally L. Satel (citing R. Hasnain-Wynia, DW Baker, D. Nerenz, J. Feinglass, AC Beal, MB Landrum, R. Behal, JS Weissman, *Archives of Internal Medicine* 167, no. 12 (2007): 1233-1239; Katherine Baicker, Amitabh Chandra, and Jonathan S. Skinner, "Geographic Variation in Health Care and the Problem of Measuring Racial Disparities," *Perspectives in Biology and Medicine* 48, no. 1, supp. (2005): S42-53).

⁴ Satel Statement (citing Katherine Baicker and Amitabh Chandra, "Myths and Misconceptions About Health Insurance," *Health Affairs* 27, no. 6 (2008) w533-w543).

⁵ See, e.g., *Adarand v. Peña*, 515 U.S. 200, 237 (1995). Justice O'Connor, writing for the majority in *Adarand*, declared that it was not true that the test was "strict in theory, but fatal in fact." *Id.* That the Court's majority had to offer that assurance, however, shows that a proper application of the test almost always is fatal. Indeed, there was not a single forward-looking preference plan (as opposed to a remedial decree) approved by the High Court between 1950 and 2003. *Grutter v. Bollinger*, 539 U.S. 306 (2003), is the first exception, and I am not alone in thinking it resulted from an erroneous application of the test.

⁶ *Adarand*, 515 U.S. at 235.

There is no compelling government interest that justifies favoring the medical training of students of some races over others. Remedying instances of actual government discrimination is a compelling government interest, but there is no evidence that health disparities are caused by past or present government discrimination. What other justifications might exist? The Supreme Court has squarely held that the role-model justification for racial preferences is not compelling,⁷ and it has never held that equalizing societal outcomes or benefits by race is a compelling government interest that justifies conscious government discrimination.

Even if Congress had a compelling government interest in equalizing health treatment or outcomes among racial populations, it would fail in showing that racial favoritism among medical students or nurses is narrowly tailored to achieve that end. That is because such race-conscious preferences will not improve health outcomes for anyone and are more likely to be counterproductive to that end. There is simply no sound evidence that race-conscious policies—such as programs designed to increase the number of minority doctors (most likely by lowering admission standards for minority applicants) or by adding cultural competency classes to medical and nursing school curricula—will improve anyone’s health care or reduce health disparities. (Even assuming minority doctors are more likely to practice in under-served areas, which is a contested claim, it is a leap of faith to assume that will result in better outcomes overall.)

Witnesses cited studies showing that the race of the doctor had almost no impact on the level of health care received by minority patients.⁸ One study in the *New England Journal of Medicine* “found that racial differences in treatment were similar among patients treated by white and black physicians.”⁹ The view that either increasing the number of minority physicians or increasing cultural competency training can mitigate health disparities “is grounded more in hope than science.”¹⁰ One of our witnesses stated that a literature search found “no rigorous evaluations of cultural competency training that attempted to answer whether it improves quality of care, let alone reduces disparities.”¹¹ Ineffectual policies are obviously not tailored, narrowly or otherwise, to achieve the policy goal of reducing racial disparities and therefore cannot pass the strict-scrutiny test.

Stripping away the noble but unsupported hunches of those who want to help minority patients, what is left are racial preferences for the sake of helping aspiring health care providers of certain races at the expense of aspiring health care providers of all other races. Whether such a policy is well meaning or not, it is unconstitutional. And lowering the admissions standards for any group of medical students, especially on the theory that they will more likely practice in under-served areas, may only make matters worse for their future patients.

⁷ *Wygant v. Jackson Bd. of Educ.*, 476 U.S. 267, 275-76 (1986).

⁸ See Chandra and Satel Statements.

⁹ Chandra Statement (citing Chen J, Rathore SS, Radford MJ, Wang Y, Krumholz HM, “Racial difference in the use of cardiac catheterization after acute myocardial infarction,” *New England Journal of Medicine* 2001; 344: 1443-1449).

¹⁰ Chandra Statement.

¹¹ Satel Statement.

Sometimes sound public policy research and constitutional rules point in opposite directions, but much more often they point in the same direction. They point very much in the same direction in evaluating government proposals to artificially increase the number of minority health care providers. Race-based policies that are ineffective or counterproductive are bad in themselves, and they can never pass the constitutional strict scrutiny test. That test was explicitly designed in the mid-twentieth century to smoke out race-conscious policies that are based on little more than racial stereotypes, false beliefs, and erroneous assumptions. Without a solid scientific foundation, government race-conscious policies in medical education, training, and treatment should be rejected as both counterproductive and unconstitutional.

Statement and Rebuttal of Commissioner Gail Heriot

In our letter of October 9, 2009 to President Barack Obama and Congressional leaders on pending health-care legislation, we noted the need to better understand the complex reasons behind racial differences in life expectancy and rates of morbidity.¹

Some of these differences are almost certainly the result of diet, exercise and other differences in life style. Genetic factors may also be at work. In both situations, knowledge can be useful. Individuals who understand how their own behavior influences their health and longevity can often change that conduct. And while genetic factors may be difficult or impossible to change, an individual who is aware of the possibility that his genetic inheritance predisposes him and his children toward particular risks may be able to guard against those risks with extra vigilance.

There is also evidence that some of the differences are the result of different medical treatment, and it is this evidence that tends to draw the greatest concern as a matter of civil rights. A good example is the likelihood that a patient will undergo cardiac catheterization after acute myocardial infarction. Several empirical studies have now concluded that white patients are more likely to receive this treatment than black patients (certain other medical indications being the same).²

The letter pointed out that some observers--misguidedly in my opinion--believe these differences in treatment to be the result of "conscious or unconscious discrimination." The solutions these observers offer have been two-fold: "expanding the number of minority physicians (even if that means lowering academic standards in medical school) and ensuring that all health care professionals receive 'cultural competency' training."³ The Commission's letter, however, made it clear that these solutions probably have little to do with the actual problem. As Dr. Amitabh Chandra of Harvard University put it at the briefing before the Commission, they are "grounded more in hope than science."⁴

¹ For example, the prevalence of high blood pressure – a risk factor for coronary heart disease, stroke, kidney disease, and heart failure – is nearly 40% greater in African-Americans than in whites (Graham Statement at 11.) Hispanics in the U.S. are 50% more likely than whites to suffer from diabetes and the incidence of diabetes among Native Americans is more than twice that for whites.

² Letter from the United States Commission on Civil Rights to President Barack Obama and Distinguished Members of Congress, October 9, 2009, *available at* <http://www.usccr.gov/corresp/CommissionHealthCareBill100909.pdf>. See Jersey Chen, Saif S. Rathmore, Martha J. Redford, Yun Wang, & Harlan M. Krumholz, *Racial Difference in the Use of Cardiac Catheterization After Acute Myocardial Infarction*, 344 N. ENGL. J.MED. 1443, 1444 n. 1-9 (May 10, 2001.)

³ *Id.* Vice Chair Thernstrom states in her Draft Statement that our briefing did not "definitively" answer the question of whether health disparities are due to racial discrimination. Draft Statement at 1. While in some sense this is surely correct, no result in social science or in medicine is ever definitive. There are always other variables for which to control and always other studies to be done. As I explain in greater detail *infra*, our briefing did provide ample evidence indicating that doctors discriminating between their black and white patients is not a significant cause of the disparities, and it would be unfair for anyone to suggest that because the evidence is not "definitive," that evidence should not be relied upon. Policymakers must always depend on less-than-perfect evidence. This research is very strong relative to that which policymakers ordinarily rely upon in analogous situations.

⁴ See Transcript, Briefing Before the U.S. Commission on Civil Rights (June 12, 2009), <http://www.usccr.gov/calendar/trnsrpt/061209ccr2.pdf>.

The evidence presented to the Commission indicates that the disparate treatment problem is "not the result of individual physicians treating their white patients differently from their black patients or of non-black physicians' lack of familiarity with African-American culture." Instead, the problem exists largely because African-American patients use different doctors, clinics and hospitals than white patients.⁵ Our letter stated:

"On the whole, the doctors who treat black patients with frequency are less likely to be highly credentialed and more likely to report obstacles in gaining access to high-quality service for their patients. As one might expect, these circumstances can lead to poorer health outcomes."⁶

Geography accounts for a good deal of the problem.⁷ For example, the Deep South is one of the poorest regions of the country, and correspondingly it has one of the poorest health care delivery systems. It also has one of the largest African-American populations. In a carepeer-reviewed, empirical study—*Geographic Variation in Health Care and the Problem of Measuring Racial Disparities*—the authors wrote that "blacks tend to live in parts of the country that have a disproportionate share of low-quality providers." "Within those hospitals, both whites and blacks tend to receive low-quality care," they wrote, "but since blacks are over-represented in such areas, the quality of the hospital will cause an overstatement of the role that race plays"⁸ The doctors are not discriminators. They may on average be less well-equipped than their peers practicing in wealthier parts of the country or on average less qualified. But they are not treating patients differently based on their race.

If all this is true, the critics who blame the problem on lack of black doctors or a lack of cultural sensitivity among non-black doctors are off the track. Under their theory, one would expect those doctors who treat black patients most frequently on average to provide the best care to those black patients. Their experience with black patients would, on average, make them more culturally competent than doctors who seldom see black patients. Yet, if anything, precisely the opposite seems to be the case.

Similarly, if the lack of black doctors were the source of the problem, one would expect that black patients being treated by black doctors would fare better than black patients treated by

⁵ Letter from the United States Commission on Civil Rights to President Barack Obama and Distinguished Members of Congress, October 9, 2009, available at <http://www.usccr.gov/correspd/CommissionHealthCareBill100909.pdf>.

⁶ *Id.* See Peter B. Bach, Hoangmi H. Pham, Deborah Schrag, Ramsey C. Tait, J. Lee Hargraves, Primary Care Physicians Who Treat blacks and Whites, 351 N. ENGL. J. MED. 6 (August 6, 2004.) The contrast under study was not between white doctors and black doctors, but rather between doctors who treat white patients and doctors who treat black patients. Both groups of doctors were majority white, although the degree of racial diversity among treating physicians who treat black patients was greater than it was among those who treat white patients. Many doctors, of course, treat large numbers of both black and white patients. See also Jonathan Skinner, Amitabh Chandra, Douglas Staiger, Julie Lee & Mark McClellan, *Mortality After Acute Myocardial Infarction in Hospitals That Disproportionately Treat Black Patients*, 112 CIRCULATION 2634, 2634 (2005) ("Risk-adjusted mortality after AMI is significantly higher in US hospitals that disproportionately serve blacks. A reduction in overall mortality at these hospitals could dramatically reduce black-white disparities in health care outcomes").

⁷ *Id.*

⁸ Katherine Baicker, Amitabh Chandra & Jonathan S. Skinner, *Geographic Variation in Health Care and the Problem of Measuring Racial Disparities*, 48 Perspectives in Biology and Med. S42, 43 (Winter 2005.)

white doctors. Yet, again, this is not so. In *Racial Differences in the Use of Cardiac Catheterization After Acute Myocardial Infarction*,⁹ the authors wrote:

“We found that black patients were significantly less likely than white patients to undergo cardiac catheterization within 60 days after admission, regardless of whether the attending physicians were white or black The rate of cardiac catheterization among white patients did not differ significantly according to whether their physicians were white or black (45.7 percent and 49.6 percent, respectively ...). Similarly, the rate of cardiac catheterization among black patients did not differ significantly according to whether their physicians were white or black (38.4 percent and 38.2 percent, respectively ...).”¹⁰

Nevertheless, the recently enacted *Patient Protection and Affordable Care Act* follows precisely the approach that these diversity advocates have supported. It contains provisions that appear to be designed to ensure that medical schools, dental schools, and other institutions that train health care professionals will give preferential treatment to members of underrepresented minorities. Failure to do so could cause these institutions to be ineligible for federal grants and contracts.¹¹ Another provision of the new law seems designed to ensure the flourishing of cultural competency programs in medical schools.¹² California and New Jersey already mandate cultural competency programs for doctors. And other states are seriously considering such a requirement.

⁹ See Jersey Chen, Saif S. Rathmore, Martha J. Redford, Yun Wang, & Harlan M. Krumholz, *Racial Difference in the Use of Cardiac Catheterization After Acute Myocardial Infarction*, 344 N. ENGL. J.MED. 1443, 1444 (May 10, 2001.)

¹⁰ *Id.* at 1445.

¹¹ For a summary of the relevant provisions of the health care legislation, please see Letter From the United States Commission on Civil Rights to President Barack Obama and Distinguished Members of Congress, October 9, 2009, available at <http://www.usccr.gov/correspd/CommissionHealthCareBill100909.pdf>.

¹²Sec. 5307 of the PPHACA (codified at 124 Stat. 628) amends 42 U.S.C. 293e, “Grants for health professions education” to read: a) Cultural competency, prevention, and public health and individuals with disability grants. (1) In general. The Secretary, acting through the Administrator of the Health Resources and Services Administration, may make awards of grants, contracts, or cooperative agreements to public and nonprofit private entities (including tribal entities) for the development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs, and for other purposes determined as appropriate by the Secretary. (2) Eligible entities. Unless specifically required otherwise in this title, the Secretary shall accept applications for grants or contracts under this section from health professions schools, academic health centers, State or local governments, or other appropriate public or private nonprofit entities (or consortia of entities, including entities promoting multidisciplinary approaches) for funding and participation in health professions training activities. The Secretary may accept applications from for-profit private entities as determined appropriate by the Secretary. (b) Collaboration. In carrying out subsection (a), the Secretary shall collaborate with health professional societies, licensing and accreditation entities, health professions schools, and experts in minority health and cultural competency, prevention, and public health and disability groups, community-based organizations, and other organizations as determined appropriate by the Secretary. The Secretary shall coordinate with curricula and research and demonstration projects developed under section 807 [42 USCS § 296e-1]. (c) Dissemination. (1) In general. Model curricula developed under this section shall be disseminated through the Internet Clearinghouse under section 270 and such other means as determined appropriate by the Secretary. (2) Evaluation. The Secretary shall evaluate the adoption and the implementation of cultural competency, prevention, and public health, and working with individuals with a disability training curricula, and the facilitate inclusion of these competency measures in quality measurement systems as appropriate. (d) Authorization of appropriations. There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2015.

It isn't just that these new laws fail to solve the problem. Despite the good intentions of those who passed them, they may well make the situation worse. By encouraging medical schools to relax admissions standards for members of certain racial groups, and inasmuch as physician quality is correlated with academic achievement, these programs may actually decrease the number of high-quality doctors that graduate from medical schools each year.¹³

Similarly, as we stated in our letter, “Emphasizing cultural competency when the lack of such competency does not appear to be the crux of the problem is not harmless. The medical school curriculum is not infinitely elastic. There are only so many hours in the day for instruction and study. Emphasizing one subject necessarily implies that another subject will not be emphasized.”¹⁴

Moreover, under the guise of cultural sensitivity, these programs are often training healthcare professionals to think in terms of clumsy stereotypes that in any other context would be regarded as silly or downright offensive. Consider the *Guide to Culturally Competent Health Care*, a popular text of this genre.¹⁵ It declares that Irish Americans “are not known for being overly modest” and that “[t]ruth is seen as a relative concept” by Mexican Americans. The same text delicately tells the reader that “most” African Americans are “present-” rather than “future-oriented,” apparently in contrast to whites, who are thus better able to plan their lives. Italian Americans, the reader is informed, tend to have superstitious beliefs. If, for example, a pregnant woman spills coffee on herself, she may believe her baby will be born “with a birth mark where the coffee was spilled.”

Other texts, like *Cultural Competence in Health Care*, contain similarly overdrawn stereotypes: Latinos are said to “generally believe that health is controlled by the environment, by fate (*distino*) and by the will of God (*manos de dios*)” and to be inclined to seek alternative care from “witches (*brujos*).” American Indians are portrayed as resentful for modern medicine as “an extension of prior colonialism.”¹⁶

Training health care professionals to communicate in their patients' native language can surely help provide them with the proper care. And basic knowledge of patients' culture and

¹³ Indeed, racial preferences in undergraduate admissions may have had the unintended consequence of lowering the number of racial minority physicians. To be a doctor, one must first complete undergraduate level pre-medical courses. Black and Hispanic students are just as likely, if not slightly more likely, than whites to plan to major in science in college. But they are much less likely to follow through on that ambition than are white students. Evidence presented before the Commission at another briefing indicates that students of all racial and ethnic groups whose entering credentials put them in the bottom third of their class are less likely to persist in science than students with identical credentials attending less competitive schools at which their credentials put them in the top third. Majoring in science is difficult, and it is easy to give up if others are getting the material more quickly. Because of racial preferences in admissions, minority students are disproportionately in the bottom third of their entering undergraduate classes, which means that they disproportionately give up on science. The result is that fewer minority students will be qualified to attend medical school after graduating college. See U.S. Commission on Civil Rights, Encouraging Minority Students in Science Careers (Statement of Commissioner Gail Heriot describing research on these points), available on the Commission's website at <http://www.usccr.gov/>.

¹⁴ See Testimony of Peter B. Bach, M.D., Briefing on Healthcare Disparities, U.S. Commission on Civil Rights at 85 (June 12, 2009).

¹⁵ Larry Purnell and Betty Paulanka, *Guide to Culturally Competent Health Care* (2004).

¹⁶ Wen-Shing Tseng and Jon Streltzer, *Cultural Competence in Health Care* (2010). See also Statement of Sally Satel at 93.

circumstances can also be important—though it is generally knowledge gained by experience and not by classroom learning. The cultural competency movement, however, is less about real cultural competency than it is about political indoctrination, patronage and paying tribute to the forces of political correctness. It has all the hallmarks of a politically correct boondoggle.